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Transforming Health Care in Alaska

2010 Report/2010-2014 Strategic Plan

Alaska Health Care Commission



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Alaska Health Care Commission

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Prepared for

Governor Sean Parnell and

The Alaska Legislature

In accordance with AS 18.09.070

January 2011

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES ALASKA HEALTH CARE COMMISSION

SEAN PARNELL, GOVERNOR

3601 C Street, Suite 902
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January 15, 2011

To: The Honorable Sean Parnell, Governor, State of Alaska
The Honorable Gary Stevens, President, Alaska State Senate
The Honorable Mike Chenault, Speaker of the Alaska House of Representatives

We are pleased to present this report of the Alaska Health Care Commission in accordance with AS 18.09.070. SB 172 was signed into law on June 21, 2010 establishing the Alaska Health Care Commission in statute (AS 18.09.010). Commission members were appointed on September 15 and the new Commission convened for the first time October 14. While the new Commission only just started their work during the last quarter of 2010 there is much to report.

The Commission was able to spend time this past quarter studying progress made during 2010 related to the Commission's 2009 recommendations and also learning about federal health reform and its implications for Alaska. The Commission will remain focused on developing Alaskan solutions to Alaska's health care challenges, but is tracking implementation of federal reform to understand how it may be affecting Alaska's health care environment. To that end, the Commission learned about provisions in the new federal law and also compiled information about action taken so far in Alaska. The Commission also contracted with the Institute for Social & Economic Research to study potential impacts of the impending changes to Alaska's health care system and Alaska's economy. This report documents what the Commission has learned.

Our greatest concern is the continuing escalation in health care costs, which is making health insurance increasingly unaffordable for Alaska's families and businesses and driving government spending for health care programs to new heights. During 2011 we will continue digging deeper into understanding this problem through new studies on health care spending trends and cost drivers, and comparisons of pricing and reimbursement for health care services in Alaska compared to other states. We will also focus on studying potential solutions, such as primary care innovation and price and quality transparency. In addition we will continue studying needs and opportunities for improving health status, supporting health workforce development, and deploying health information technology. These plans are included in this report.

We are grateful for the foresight of the Alaska Legislature and Governor Parnell in establishing the Commission in statute and providing resources to support continuing work to address the challenge of transforming Alaska's health care system so that it is sustainable, provides value for Alaskans' health care dollar, meets the needs of patients and providers, and focuses on health.

Sincerely,
Ward B. Hurlburt, MD, MPH
Chair, Alaska Health Care Commission
Chief Medical Officer & Public Health Director
Department of Health & Social Services

Deborah Erickson
Executive Director
Alaska Health Care Commission

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APPENDICES Available on the Commission’s Web Site at: <http://hss.state.ak.us/healthcommission/>

Appendix A: Commission’s Health Care Transformation Strategies

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Executive Summary

Background

The Alaska Health Care Commission was established in Chapter 9 of Title 18 in Alaska Statute this year with the implementation of SB 172, which was signed into law by Governor Parnell in June 2010. Commission members were appointed in September and the new Commission convened for the first time in October. The new body continued the work of the original Commission which was organized and met during 2009 under Governor's Administrative Order #246. This report reflects work accomplished since the launch of the new Commission in the last quarter of 2010, describes how it builds on and continues the work begun in 2009, and lays the groundwork for 2011 activities.

The Commission's process for transforming Alaska's health care system began with identification of a vision, goals and values of the ideal system, and is now in a continuing cycle of learning about current challenges, designing policies for achieving the vision, and evaluating progress. The core of the transformation strategy rests on building a strong foundation for the system through health workforce development, deployment of health information technology, and statewide leadership. The focus of the core transformation strategy is to strengthen the consumer's role in health through innovations in patient-centered care and by fostering healthy lifestyles.

Understanding Alaska's Health Care Challenges

To better understand why Alaska's health care system is not achieving the vision, the Commission started in 2009 by describing how health care in Alaska is delivered and funded (Appendix A of the 2009 report). Particular concerns identified in the 2009 report included that:

- The high and rising cost of health care in Alaska is unsustainable;
- Health insurance coverage in Alaska is inadequate;
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services;
- Fragmentation and duplication in Alaska's health care system creates inefficiencies;
- Alaska suffers from shortages and maldistribution of health care workers;
- Health status, health risk behaviors and changing demographics contribute to high utilization of health care services;
- The State of Alaska does not have an infrastructure and capacity to provide leadership for health care system improvement;
- Use of modern health information technology is taking hold in Alaska, but much remains to be done; and,
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care.

In 2010 the Commission added to learning about Alaska's health care system challenges by compiling information on the new federal health care reform law. In addition to reviewing and providing summaries of the law's provisions and noting activities related to implementation in Alaska that occurred during 2010, the Commission also contracted with the Institute for Social & Economic Research to provide an analysis of the potential economic impact of the law on Alaska.

In 2011 the Commission will continue studying current challenges in Alaska health care delivery and financing with a focus on health care spending trends and cost drivers, pricing and reimbursement for health services, and health conditions contributing to utilization of services. The Commission will also review the status of statewide planning for long term care and for trauma system improvement.

Alaska Health Care System Transformation Strategies

The Commission's 2009 recommendations for health care system transformation still stand – the Commission is building on those recommendations to develop a mosaic of strategies intended to increase value, improve access and support prevention. These strategies focus on enhancing the consumer's role in health through supporting healthy lifestyles and fostering innovations in health care delivery, building statewide leadership for health policy development, strengthening the supply and distribution of health care workers, promoting the use of health information technology, and improving access to primary care for Medicare enrollees.

2010 saw a number of developments related to the Commission's 2009 recommendations.

- **Consumers' Role/Healthy Lifestyles:** Governor Parnell launched a domestic violence and sexual assault initiative aimed at preventing harm through creating a culture of respectful relationships. The Commissioners of the Departments of Health & Social Services (DHSS) and Education & Early Development collaborated to convene a task force targeting obesity prevention and control among Alaska's school children. The legislature invested in the state's obesity and control program, and Alaska's first food policy council was created to improve the supply and distribution of Alaska-produced foods and improve the nutrition literacy of Alaskans.
- **Consumer's Role/Primary Care Innovation:** DHSS received federal grant funds that will be used to pilot test and evaluate patient-centered medical homes for children; a number of Alaska health care organizations are implementing the patient-centered medical home model in their practices and seeking NCQA recognition; and the Alaska Primary Care Association began an initiative to support Alaska's 142 community health center sites' movement towards adoption of innovative care models.
- **Statewide Leadership:** Creation of the Alaska Health Care Commission in AS 18.09.010 this year implemented the recommendation for a permanent state health planning and policy body. No new resources were allocated to support analysis and implementation of federal health care reform due to the state challenge regarding constitutionality of the new law and questions regarding severability of the challenged provisions from the whole law; however, state agencies and other organizations are tracking federal implementation, complying with legally mandated requirements, and investigating optional provisions that align with existing policies and programs.
- **Health Workforce Development:** The Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan," which was adopted by the Alaska Workforce Investment Board in May, and received a federal grant to develop a strategic plan for implementing the comprehensive plan. None of the proposed bills that would have created and funded a state health professions educational loan repayment and financial incentive program passed during the 2010 session, but a federal grant with matching funds from stakeholders enabled the creation of such a program for at least one year. Two new primary care residency programs for training pediatricians and psychiatrists in Alaska are closer to reality with progress made in planning during the year.
- **Health Information Technology:** DHSS awarded the State Health Information Exchange (HIE) Entity grant to the Alaska eHealth Network (AeHN) in April, and in November AeHN awarded a contract to Orion Health to build the system. AeHN also received a federal grant to establish a regional health IT extension center to provide technical assistance to health care providers. The Alaska EHR Alliance established preferred vendor agreements with two electronic health record (EHR) vendors to simplify the selection process and guarantee reduced pricing for Alaska providers. Broadband telecommunications service providers received \$117 million in federal grants to support expansion in rural communities; and Connect Alaska, a new non-profit formed to expand broadband access, was created and launched Alaska's first statewide interactive online broadband availability map.

- **Medicare Access:** A new clinic intended to alleviate the primary care access problem for seniors in the Mat-Su was opened this year, and two new clinics devoted to providing health care for seniors in Anchorage were planned during 2010 and will open early in 2011: The Senior Care Center at Providence, which is subsidized by Providence Health & Services, and the Alaska Medicare Clinic, which is subsidized by a FY 11 state capital grant. In addition the Anchorage Neighborhood Health Center will open doors of a new clinic doubled in size with more room and staff to accommodate additional Medicare recipients and medical clinic space devoted to seniors.

New 2010 Recommendations made by the Commission relate to the significance of **Evidence-Based Medicine** for improving the quality of health care by emphasizing the need for critical assessment skills in understanding and applying findings from medical research to clinical practice and to health care policies. The importance of protecting the practitioner's and the patient's role in making clinical decisions is emphasized. The importance of shared decision-making and also patient compliance is recognized to balance reliance on the medical system to improve quality. The need for reliable data and information to guide decision-making is also noted.

The Commission has identified a number of additional strategies to study and consider for 2011 recommendations. For improving value – by increasing quality and controlling costs – the Commission will analyze additional strategies for fostering patient-centered primary care, mechanisms for providing transparency in health care pricing and quality, bundled payment systems, and the possibility of leveraging state purchasing power to drive quality improvement. For supporting community efforts to foster healthy lifestyles, the Commission will consider the need for an on-line interactive public health information system. To strengthen statewide leadership, the Commission will finalize a set of indicators for measuring improvement in Alaska's health care system over time.

Part I: Introduction

A. Purpose of this Report

The purpose of this report is to convey the 2010 findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Alaska Statute 18.09.070. This report builds on the work of the original Alaska Health Care Commission (created by Governor Palin under Administrative Order #246) which in their 2009 Report presented a 5-year strategic planning framework as a “roadmap” for strengthening Alaska’s health care delivery system. The 2009 report was described as a living document meant to evolve each year as problems of health care quality, cost and access are studied, potential solutions are analyzed, and implemented strategies are evaluated. This new report documents the continuation of that process.

Included in this report are:

- Part I: an introduction including background on the Commission, a summary of the Commission’s 2010 activities, and a description of the Commission’s strategic planning framework;
- Part II: information on the challenges of delivering and accessing health care in Alaska, and plans for additional study of current challenges in 2011;
- Part III: the Commission’s recommendations for transformation of Alaska’s health care system, including a status report on implementation of the Commission’s 2009 recommendations, findings and recommendations on the one new strategy studied this year, and strategies that will be considered in 2011;
- Appendices: information on the new federal health care law and its implementation in Alaska, an analysis of the potential economic impact on Alaska of the new federal health care law, and additional information by and about the Commission.

B. Background on the Commission

The Alaska Health Care Commission was first established by Governor Palin on December 4, 2008 under Administrative Order #246. Original Commission members were appointed on January 27, 2009 and the Commission met throughout 2009, producing a report on their findings and recommendations in January 2010. The Commission created under A.O. #246 terminated with the production of that report.

The Alaska Health Care Commission was established in state statute (AS 18.09.010) this year with the passage of Senate Bill (SB) 172 to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. SB 172 was passed by the Alaska Legislature on April 17, 2010 and subsequently signed into law by Governor Parnell on June 21, 2010.

Duties of the Commission prescribed by AS 18.09.070:

- I. Serve as the state health planning and coordinating body;
- II. Provide recommendations for and foster the development of a:
 1. Comprehensive statewide health care policy;

2. Strategy for improving the health of Alaskans that
 - i. Encourages personal responsibility for disease prevention, healthy living and acquisition of health insurance;
 - ii. Reduces health care costs;
 - iii. Eliminates known health risks, including unsafe water and wastewater systems;
 - iv. Develops a sustainable health care workforce;
 - v. Improves access to quality health care; and,
 - vi. Increases the number of insurance options for health care services.
- III. Submit a report to the Governor and the Legislature by January 15 of each year regarding the Commission's recommendations and activities.

Former Commission members were reappointed under the transition clause included in SB 172, and new members were appointed by Governor Parnell September 15, 2010. Legislative representatives were reappointed by their respective bodies. Short biographies for each of the Commission members are provided on the Commission's web site at www.hss.state.ak.us/healthcarecommission. The members of the Commission are:

Ward Hurlburt, MD, MPH: Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.

Patrick Branco: Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of Ketchikan General Hospital; Ketchikan.

C. Keith Campbell: Representing consumers; retired hospital administrator and former AARP Chair; Seward.

Valerie Davidson: Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.

Jeffrey Davis: Representing Alaska's health insurance industry; President of Premier Blue Cross Blue Shield of Alaska; Anchorage.

Emily Ennis: Representing the Alaska Mental Health Trust Authority; Executive Director of Fairbanks Resource Agency; Fairbanks.

Col. Paul Friedrichs, MD: Representing the U.S. Department of Veterans Affairs health care system; Commander of the Air Force/Veterans' Affairs Joint Venture Hospital at Elmendorf; Anchorage.

T. Noah Laufer, MD: Representing primary care physicians; family medicine physician and president of Medical Park Family Care; Anchorage.

David Morgan: Representing community health centers; Reimbursement Director for the Southcentral Foundation; Anchorage.

Wayne Stevens: Representing the Alaska State Chamber of Commerce; President & CEO of the Alaska State Chamber of Commerce; Juneau.

Lawrence Stinson, MD: Representing Alaska health care providers; anesthesiologist and co-owner of Advanced Pain Centers of Alaska; Anchorage.

Linda Hall (Ex-Officio): Representing the Governor's Office; Director of the Alaska Division of Insurance; Anchorage.

Representative Wes Keller (Ex-Officio): Representing the Alaska House of Representatives; Wasilla.

Senator Donny Olson (Ex-Officio): Representing the Alaska Senate; Golovin.

C. Summary of 2010 Activities

The formal work of the Commission was paused for the first 9 months of 2010 following termination of the 2009 Commission until the new body was established in statute and members were appointed in September. The group was then able to hold two face-to-face meetings during 2010, one in October and one in November. At these first meetings the new members were introduced to the work of the 2009 Commission, and the group received updates on several issues studied during the previous year. Despite the short timeframe available for developing this year's annual report, the Commission:

1. Revised their Core Transformation Strategy
2. Developed recommendations for a key strategy to improve value: Evidence-based Medicine
3. Identified issues to be analyzed in 2011
4. Prioritized new policy options for study and recommendation development in 2011.

2010 Accomplishments

Meetings and public hearings: During 2010 the Commission held three face-to-face meetings, all in Anchorage: January 8 (this was the last meeting of the 2009 Commission to incorporate changes based on public comment, finalize and approve the 2009 report to the Governor and legislature); October 14-15; and November 16-17. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend in person but interested in listening to the meeting or providing public testimony. Summaries of the meetings and the Commission's voting record are included in Appendix D of this report. Public hearings were held during both the October and November meetings, and a summary of comments received from the public is also included in Appendix D.

Administration: In their first months the new Commission reviewed meeting rules, updated and approved changes to the by-laws, approved a budget for SFY 2011, and received ethics training from the State's ethics attorney. A copy of the Commission's meeting rules, by-laws, SFY 2011 budget, and ethics handbook are available on the Commission's website (see website address below).

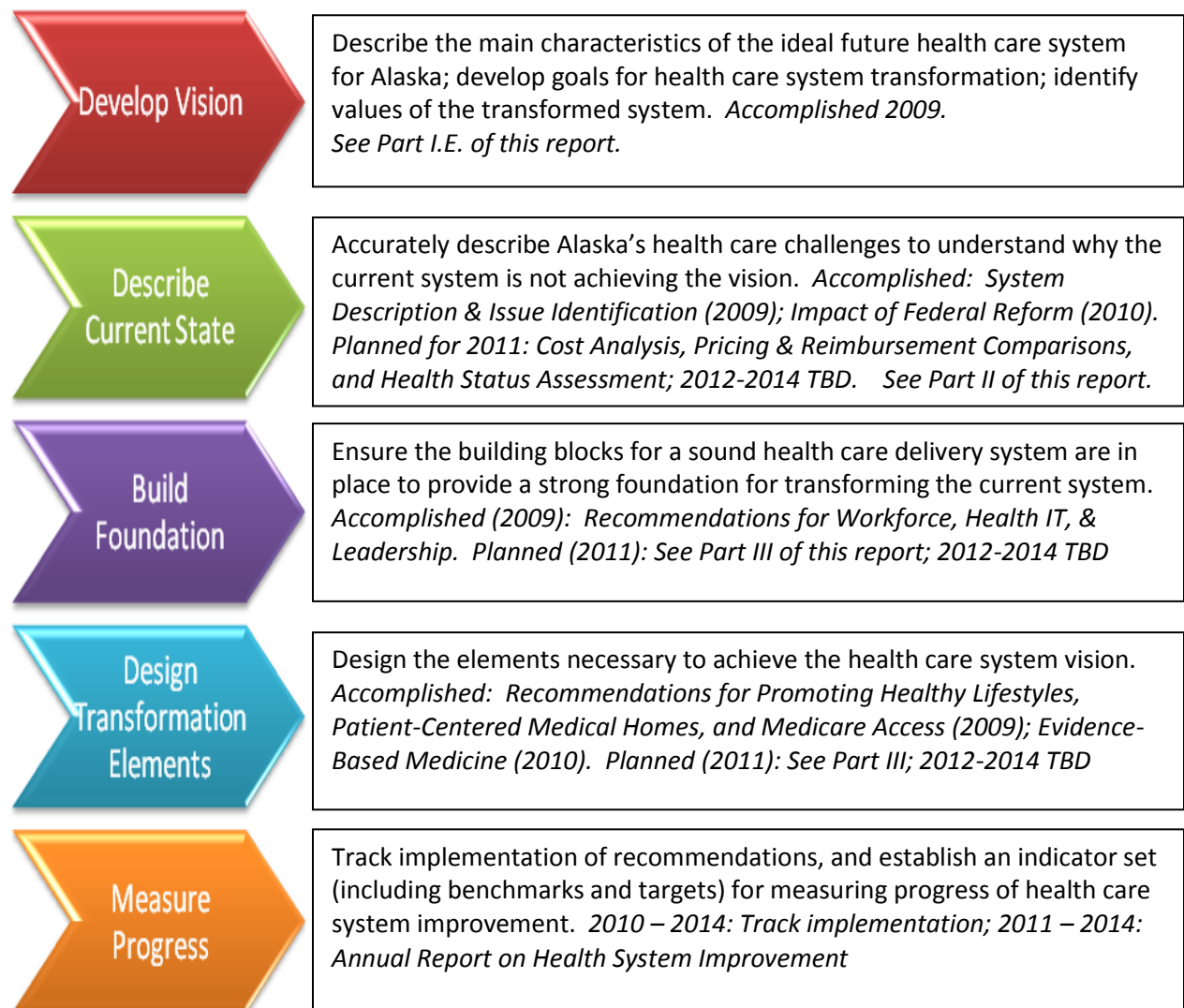
Communication and coordination: The Commission updated and maintained a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (<http://hss.state.ak.us/healthcommission/>). A listserv established in 2009 to maintain communication with system stakeholders and members of the public interested in receiving periodic updates was also updated, expanded and utilized. The Commission also maintained an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (also available on the website).

Products: The main product from 2010 is this annual report, which includes analysis and recommendations related to the value-improvement strategy of evidence-based medicine, and an overview and analysis of potential impact of the new federal health care law (P.L. 111-148, the Affordable Care Act) on Alaska.

D. 2010 – 2014 Strategic Plan Framework

In 2009 the initial Commission developed a 5-year strategic planning framework to guide the process for improvement of Alaska's health care system. The new Commission is following the same process, depicted graphically below with a brief note about the status of implementing each process step. Note that except for the first step of developing a vision the process is not sequential - the steps in the process are being implemented concurrently and continually.

Strategic Planning Process & Implementation Status



E. The Commission's Vision for Transformation of Alaska's Health Care System

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and behavioral, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the state of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, some are private business. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment. A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of their consumers.

Vision

Alaska's Health Care System

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The first step in the Commission's journey toward transformation of Alaska's health care system was to design a picture of the ideal system. The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center of their health experience and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system is one that is sustainable over time.

Health Care Goals

- I. Improved Access
- II. Contained Cost
- III. Safe, High Quality Care
- IV. Prevention-Based

The Commission also identified four goals for a transformed health care system to support a targeted approach to identification of improvement strategies and performance measurement.

- I. **Access:** Access to affordable health care coverage and to a viable and vital health care delivery system is improved.
- II. **Cost:** The cost of health care is controlled so that the medical inflation rate in Alaska is below the national rate.
- III. **Quality:** Alaskans can be assured that health care services they receive in Alaska meet the highest quality and safety standards.
- IV. **Prevention:** A focus on preventive services, both clinical preventive services for individuals and community prevention policies, will support improved health status and control costs by reducing the burden of preventable disease and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission agreed to the following set of values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of:

1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.

Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.

Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.

Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.

Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care.

F. Core Transformation Strategy

The figure below depicts in graphic form the core strategies identified by the Commission for transforming Alaska's health care system to achieve their vision, and the relationship of those strategies to one another and to the planning process.

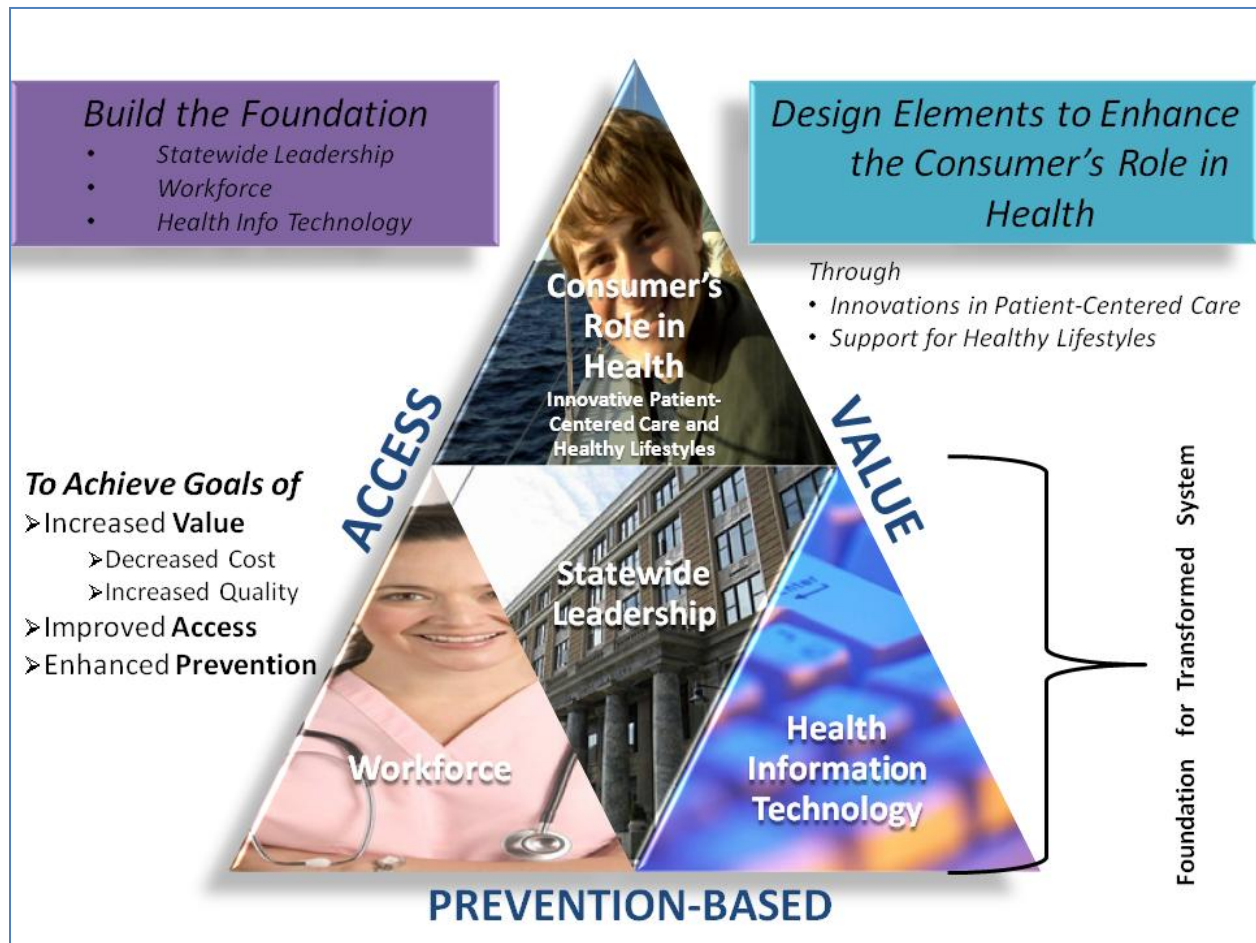


Figure 1: Alaska Health Care Commission's Core Strategy for Health Care System Transformation

Understanding and supporting the consumer's role in health care is the central focus of Commission's strategic approach to transformation of Alaska's health care system. Two aspects of the consumer's role are critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and an innovative patient-centered system depend. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

Part II: Understanding Alaska's Health Care System Challenges

A. Summary of 2009 Findings

To better understand why Alaska's health care system is not achieving the Commission's vision, the 2009 Commission started by describing how health care in Alaska is delivered and funded (Appendix A of the 2009 report). The commission also received numerous presentations and reviewed existing reports to identify a series of challenges that contribute to the current problems in the system. Particular concerns identified in the 2009 report included that:

- The high and rising cost of health care in Alaska is unsustainable;
- Health insurance coverage in Alaska is inadequate;
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services;
- Fragmentation and duplication in Alaska's health care system creates inefficiencies;
- Alaska suffers from shortages and maldistribution of health care workers;
- Health status, health risk behaviors and changing demographics contribute to high utilization of health care services;
- The State of Alaska does not have an infrastructure and capacity to provide leadership for health care system improvement;
- Use of modern health information technology is taking hold in Alaska, but much remains to be done; and,
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care

Health Care Costs: Health care spending in the U.S. has been growing faster than the economy for decades, doubling from 8% of the nation's GDP in 1970 to 16% in 2006 and projected to increase to 20% by 2016. Per capita national health care expenditures in the U.S. increased 850% over the past three decades. High costs for health care contribute to higher prices for goods and services produced in the U.S., challenging our ability to maintain a competitive edge in the global market place.

In 1993 the Alaska Health Resource & Access Task Force projected health care spending in Alaska would "sky-rocket" from slightly below \$1.9 billion in 1991 to nearly \$5.6 billion in 2003. In 2009 spending was estimated at over \$6 billion. State general fund expenditures for Medicaid grew more than five-fold between FY 91 and FY 08 from a little over \$80 million to over \$408 million. In 2005 government paid 64% of Alaska's health care bills, private employers paid 17%, and individual Alaskans paid 19%.

Alaska has the highest annual Medicaid expenditure level per enrollee in the U.S. Alaska has also ranked 1st in the nation for cost of workers' compensation premium rates since 2005, with medical costs making up 72% of total benefit claims in Alaska in 2008 compared to the national average of 58%. Signs that prices for health care are higher in Alaska than other states include differences in reimbursement rates between our Medicaid and Workers Comp programs and those of other states. A comparison of Alaska's Medicaid rates to Washington state's indicate our fees are two to three times higher. Alaska's Workers' Comp medical fee schedule rates were the highest in the nation in 2006 – on average 3.5 times higher than Massachusetts (the state with the lowest rates).

Health Insurance Coverage: Increased spending for health care translates into higher insurance premiums, as health insurance providers adjust to cover rising prices and growing utilization. In Alaska health insurance premiums for working families grew by 90.8% between 2000 and 2009. In comparison, the median earnings of Alaska's workers rose 17% during the same period. The average annual premium for individual health coverage rose from \$2,923 to \$5,626 during that same period. The percentage of income spent on health care in Alaska increased steadily from 11% in 1991 to 19% in 2004.

14% of Alaskans are uninsured or do not have access to military, Veteran's Administration or Indian Health Service beneficiary health care services. 84% of uninsured Alaskans belong to households with one or more workers. Most uninsured workers are self-employed, or employed in small businesses that do not offer health benefits or offer coverage they cannot afford. Nearly all Alaskan firms with more than 100 employees provide health benefits, while less than a quarter of Alaska's smallest businesses (<10 employees) offer insurance. The seasonal nature of Alaska's workforce is an important factor in employer health coverage – data on coverage does not account for those who are insured only part of the year. There is also insufficient data on Alaskans who are underinsured – those who have coverage but with such high deductibles and co-pay that they still cannot afford care.

Logistical Challenges: The dispersion of Alaska's relatively small population over a large geographic area increases the cost and complexity of delivering care here. Approximately 75% of Alaska's communities are not connected by road to a community with a hospital, and nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft.¹ Transportation costs associated both with patient travel and also with moving supplies, staff and equipment to operate clinics and hospitals in rural Alaska can be formidable.

The cost of delivering services is also made higher by a loss of economies of scale associated with operating hospitals in sparsely populated regions and clinics in nearly every small community in the state – a necessity due to the remoteness and isolation of those locations. Some of Alaska's smallest communities with a clinic have as few as 50 residents. However, the loss of economies of scale to maintain the facilities is off-set somewhat by the innovative workforce solutions used to staff them, such as the Community Health Aide/Practitioner Program, and the use of telehealth technologies.

Health System Fragmentation and Duplication: Alaska's health care "system" is not a system, but an assortment of private, for-profit and non-profit, large and small medical businesses; hospitals and clinics to serve military personnel, retirees and their dependents; and hospitals and clinics owned and operated by tribal organizations. Health care organizations within the same sector (military, tribal health system, or private sector) do not have interoperable electronic information systems, care coordination systems, or business management processes. In addition to fragmentation in the delivery of services, there are a variety of payers financing health care services, including Medicare, Medicaid, private insurers, self-insured employers, the military and VA, the Indian Health Service, and individuals.

Some communities have multiple health care systems operating side-by-side. For example, one community of 9,000 people has both a community hospital and a tribal health system hospital. Another community of just 6,000 people has a community hospital, a tribal health system clinic, and a military clinic. Alaska's largest city, with a relatively small population of 285,000, has four hospitals – one military, one tribal, one for-profit, and one non-profit (plus two psychiatric hospitals). The facilities in these communities also serve regional (and in the largest city's case statewide) populations, but there is still an overabundance of infrastructure that leads to higher costs.

Health Care Workforce Shortages: Demand for health care workers rose sharply over the past decade. Alaska's health care employment sector experienced 40% job growth between 2000 and 2007, compared to 13% for all other industries, outpacing the state's population growth during that same period by five times.ⁱⁱ The supply of new workers produced by Alaska's training and education programs plus those imported from outside Alaska cannot keep up.

Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations are experiencing vacancy rates of 15% - 20%. Pharmacist, therapist and certain nurse specialist positions are also experiencing high vacancy rates. Behavioral health occupations have a somewhat lower vacancy rate overall, but made up the highest proportion of vacancies with 1,033 vacant positions in 2007.ⁱⁱⁱ

Health Status, Health Risk Behaviors and Changing Demographics: Health conditions and demographics drive utilization of health care services and spending for health care services. Alaska experiences high rates of chronic disease, behavioral health conditions, and injuries. Three health risk behaviors (tobacco use, poor diet, and inactivity) are the primary contributors to development of chronic diseases such as heart disease, diabetes, lung disease, and cancer. Tobacco use in Alaska has been declining due to significant investment of resources in prevention and control, but increases in Alaska's rates of obesity are alarming. The total population of Alaska is steadily increasing, and the number of Alaskans aged 65 and older has more than doubled over the past two decades and is projected to nearly triple again by the year 2030.

Statewide Leadership for Health Care System Improvement: Over the two decades preceding the creation of the Commission four groups had been formally convened to address the problems of access to and cost of health care. All of those entities had been ad-hoc in nature and met over periods ranging from 6 months to 2 years. Existing resources for health care planning are fragmented, and also insufficient for analyzing the complexity of pending federal health care reforms for their impact on Alaska. Lack of sustainable capacity and a coordinated, long-term approach to health care planning and policy development hampers the ability to provide statewide leadership for health care system improvement.

Health Information Technology: There is significant governmental and private sector interest in deploying the use of health information technology to improve efficiency and effectiveness of health care. President Bush established the Office of the National Coordinator for Health Information Technology in 2004, and in 2009 Congress appropriated more than \$20 billion for the development and adoption of health information technology under the HITECH Act. The Alaska Legislature passed SB 133 during the 2009 session to create a statewide health information exchange (HIE) system for Alaska. Two non-governmental organizations in the state – the Alaska eHealth Network and the Alaska EHR Alliance formed in recent years to support implementation of electronic health records (EHRs) in physician practices and foster the development of a HIE.

There is also a history of innovative uses of telecommunications technologies for delivering health care in Alaska, and now growing support for development and utilization of these technologies. The Alaska Federal Health Care Access Network provides telehealth applications to 248 sites throughout Alaska. Other telemedicine programs involved in improving access to health care in the state include the Alaska Rural Telehealth Network, Providence's REACH system and eICU, the Alaska Psychiatric Institute's Telebehavioral Health Care Services Program, and the Southeast Alaska Regional Health Consortium

Telebehavioral Health Program. Insufficient access to broadband telecommunication services hampers further development and deployment of telehealth in some rural communities.

Medicare Enrollee Access to Primary Care: A study conducted by the Institute for Social & Economic Research in 2008 confirmed anecdotal information that many Alaskan Medicare beneficiaries living in urban communities, particularly Anchorage, have trouble finding a primary care physician to take them as a patient. The researchers found that only 17% of Anchorage primary care physicians accept new Medicare patients compared to 61% nationally.

Finding Statements from 2009 Report: Following are the Finding Statements included in the 2009 report associated with each of the core strategies that were studied and for which recommendations were developed.

Strengthen the Consumer's Role – Support Healthy Lifestyles

- Chronic disease is the leading cause of death and disability in the U.S. and Alaska.
- The majority of health care spending in the U.S. is for chronic disease.
- Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.
- Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.
- Childhood obesity is a growing concern; for example, 33% of kindergarten and 1st grade students in the Anchorage School District are overweight or obese.
- Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

Strengthen the Consumer's Role – Foster Innovative Primary Care Models

- Patient-centric health care delivery models based on a longitudinal relationship-based platform are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care.

Develop Statewide Leadership – Response to National Health Care Reform

- National health care reform proposals under consideration by Congress will have a significant impact on Alaska's state and local governments, health care system, business community, citizens, and families.

Develop Statewide Leadership – State Health Policy Board

- The systems and policies for financing and delivering health care in Alaska are fragmented and complex, and the scope of the challenges involved in improving these systems is huge. Past efforts to improve health care in Alaska have been ad hoc in nature. A planning process to achieve health care system improvement must be sustained over time in order to ensure accountability for the achievement of meaningful change.

Develop the Health Care Workforce

- Health care in Alaska is big business and represents a significant employment sector.
- Access to health care requires a sufficient supply and adequate distribution of health care providers. Successful achievement of the goal of expanding access to health care in Alaska is directly tied to health care workforce capacity and capability.

- Health care worker shortages in Alaska are widespread and costly.
- A comprehensive approach to health care workforce training includes strategies at every point on the training continuum (K12, post-secondary, graduate and post-graduate, on-the-job, continuing medical education).
- Alaskans have been particularly innovative in meeting their health care workforce needs.
- Many organizations, both public and private, have a stake in health care workforce development, and there are numerous programs and groups currently involved in health care workforce planning. There is evidence of collaboration in these planning and development efforts; however, not all related activities are fully coordinated.

Workforce – Physician Supply

- The United States is facing a shortage of physicians as this provider population ages and enters retirement and the production is not expected to keep up with demand. As the physician shortage increases in the U.S. the competition for recruiting physicians to Alaska will become increasingly difficult.
- Alaska has a shortage of primary care physicians¹.
- New physicians face disincentives to entering primary care specialties.
- Providers stay to practice where they train.
- Mid-level medical practitioners (Nurse Practitioners and Physician's Assistants) and medical support staff (nurses, medical assistants, care coordinators, etc.) are essential occupations for addressing primary care physician shortages.

Deploy Health Information Technology

- Development and utilization of electronic information management tools is essential to health care system improvement for the purpose of supporting:
 - Increased health care efficiency and effectiveness; and
 - Improved clinical quality and patient safety.

Deploy Health Information Technology – Electronic Health Records

- Many providers in Alaska are at the early end of adopting electronic health records. Many still use paper records. Barriers to adoption of electronic health information technologies by Alaska's health care providers include:
 - Start-up costs for new systems, including purchase of new hardware and software as well as costs associated with implementing new office procedures, training staff, and transitioning existing records from paper to electronic;
 - The multitude of products on the market making evaluation and selection of one system time-consuming and costly for individual providers in small practices;
 - Systems that are not user-friendly from the provider's perspective, i.e., are difficult, inflexible and time-consuming to use;
 - Costs associated with on-going operation and maintenance; and,
 - Antiquated and nonstandard eligibility and claims processing systems.

¹ The Commission includes both osteopathic as well as allopathic medical doctors in their definition of physician. The Commission's definition of primary care physician is slightly different from most standard definitions – family practitioners, pediatricians, and general internists are included, but also psychiatrists, and Ob-Gyns are excluded.

- Federal policies, such as the national incentive program funded under ARRA and pending Medicare payment penalties, are forcing rapid adoption of electronic health records by providers. Some Alaskan providers feel forced to move forward quickly while being concerned that standards are not yet fully in place and systems may not be ready.

Deploy Health Information Technology – Ensure Privacy & Security

- Alaskans are concerned about the privacy of their personal health information. Progress has been made by the federal government to develop national health information security and privacy protection standards, and Alaskans have participated in these efforts, but more work remains to be done.

Deploy Health Information Technology – Telehealth/Telemedicine

- Alaskans have been particularly innovative in the use of telecommunications technologies as one way to bridge our vast geography and address health care access challenges.
- Barriers to adoption and use of telemedicine include:²
 - Insufficient telecommunications connectivity in some rural Alaskan communities;
 - Inadequate access to training for providers and their staff;
 - Medical licensure restrictions across state borders;
 - Misalignment of payment systems between costs and benefits.

Improve Access to Primary Care for Medicare Beneficiaries

- Alaska's Medicare-eligible population is growing.
- Medicare patients in some areas of Alaska experience trouble accessing primary care. The communities experiencing the most trouble with access are those with larger populations, notably Anchorage.
- One contributor to the Medicare access problem is an insufficient supply of primary care physicians willing to accept and retain Medicare patients in larger urban centers.
- Health care providers report Medicare's burdensome administrative requirements, onerous audits, and what they find to be insufficient reimbursement rates as the primary reasons for limiting or denying provision of Medicare services.
- Care for Medicare patients is often more complex and time-intensive than for the general patient population.
- Mid-level practitioners are increasingly being used to solve the Medicare access problem.
- Health care providers report Medicare's physician and mid-level practitioner reimbursement schemes are not rational and not reliable.
- Health care providers commonly report that Medicare's audit process designed to weed out fraud and abuse in the system focuses more on identification of billing errors than intentional fraud, incentivizes audit contractors to pursue and penalize providers for unintentional billing errors, and unnecessarily places an onerous administrative and legal burden on providers. The audit process, which appears to physicians to be based on an assumption of guilt, serves as a disincentive for Alaska providers to provide care for Medicare patients.

² The order of the bullets in this finding is not meant to imply priority order of significance.

B. 2010 Analysis: Overview & Impact of the Federal Health Care Law

For their 2010 report the Commission compiled summary information on the new federal health care law and Alaska's response to enacted provisions to-date. The Commission is not charged with developing recommendations on the implementation of federal reform, but plans to track implementation in order to understand how the law may affect the health care landscape in Alaska as they continue developing state-specific solutions to Alaska's health care challenges. As part of this effort the Commission contracted with the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage to provide a report on the projected economic impact of the new law on Alaska.

An overview of the law, brief information on enactment status in Alaska to-date, and a summary of preliminary estimates of the health care and economic impact to Alaska are provided in this section. Additional information and the full ISER report are included in Appendices B and C.

Overview & Status in Alaska

Federal health care reform is enacted under three new federal laws passed in March and April 2010:

- P.L. 111-148: The Patient Protection and Affordable Care Act (PPACA)
- P.L. 111-152: The Health Care and Education Reconciliation Act
- P.L. 111-159: The TRICARE Affirmation Act

PPACA is structured as follows (the names of these titles do not reflect the exact names assigned in the legislation – they are modified to be more descriptive):

Title I	Private Health Care Coverage
Title II	Public Health Care Coverage (primarily Medicaid changes)
Title III	Health Care Delivery and Payment (primarily Medicare changes)
Title IV	Prevention and Public Health
Title V	Health Care Workforce
Title VI	Fraud, Waste and Abuse
Title VII	Pharmaceuticals
Title VIII	CLASS Act (Community Living Assistance Services & Supports)
Title IX	Taxes and Fees
Title X	Amendments (changes made to the original bill (Titles I-IX) prior to passage)

This overview describes PPACA as amended by Title X and the two subsequent laws. The provisions described in this overview take effect at various points over the next eight to ten years. A number of key provisions took effect during 2010. Most of the more significant changes take effect in 2014.

Title I – Private Health Care Coverage

The private health care coverage provisions set forth in Title I impose a series of new rules on health insurance plans, create state-based Health Insurance Exchanges, create a number of new health insurance programs, require individuals and employers to participate in purchasing health coverage or pay a penalty, and provide subsidies for low-income individuals, small businesses, and employers providing health insurance for early retirees.

New health insurance rules include prohibitions against pre-existing condition exclusions, lifetime and annual limits, and coverage rescissions. They also require expansion of coverage to dependents up to 26 years of age and require benefit packages to include clinical preventive services. Health insurers are required to guarantee issuance and renewal of coverage. A minimum Medical Loss Ratio (MLR) will be imposed, requiring insurance companies to pay out 85% of their premium revenue in medical claims (80% for insurers covering the individual and small group market). New community rating rules will limit variations in rates to certain ratios based only on age, region, family composition and tobacco use. Risk adjustment will be required in individual and small group markets and in the Exchange. This title also imposes a series of new administrative simplification and standardization requirements on insurance plans. Grants are made available to States to conduct premium rate reviews, and to establish an Office of Health Insurance Consumer Assistance to assist and advocate for consumers with private coverage in the individual and small group markets.

A Health Insurance Exchange will be established for every state by 2014. The Exchanges are intended to provide an electronic web-based marketplace where individuals and small businesses of under 100 employees (and eventually large businesses) will be able to comparison shop for health plans. State governments are given the option of designing and establishing the Exchanges, and federal planning grants are provided to States choosing to develop their own Exchange. States are also given the option of partnering with other States to create regional or multi-state Exchanges. The Exchanges may be administered by a government agency or non-profit entity, and are required to be self-sustaining within one year of implementation. The federal government will establish Exchanges for the states in which the State government chooses not to participate.

Other health insurance programs and entities that are established in Title I include 1) a temporary high risk health insurance pool program, intended to offer coverage to those with pre-existing conditions until the prohibition on exclusions takes effect (for children for plan years starting after 9/23/10; for adults for plan years starting after 1/1/14); 2) a temporary (2010 – 2014) early-retiree reinsurance program that will subsidize health plans provided by employers offering insurance to retirees not yet qualified for Medicare; 3) a Health Care Cooperative program, which will create non-profit member-operated health insurance companies in each state; 4) Health Choice Compacts, which will allow insurance companies to sell plans across state lines for those States that have entered into a compact agreement; and 5) Multi-State Health Plans that the federal Office of Personnel Management will establish in every state.

Individuals will be required to have a qualified health plan or pay a tax penalty. The tax penalty will be \$695/year (family penalty capped at 3-times the individual penalty, or \$2,085) or 2.5% of household income (whichever is greater), and will be phased in starting in 2014 reaching the full amount noted here in 2016 (and indexed to CPI thereafter). Exemptions to the individual mandate apply for financial hardship, religious objections, American Indians/Alaskan Natives (due to the federal government's trust obligation under treaty to provide their health care), and if the lowest cost coverage option exceeds 8% of household income.

U.S. citizens and legal immigrants with incomes between 133% - 400% of federal poverty level (FPL) whose employer does not offer coverage with a value of at least 60%, or for which the employee's contribution is 9.5% of income, will be eligible for subsidies in the form of premium credits. Amounts of the credits will be tied to the cost of certain plans in the region and set on a sliding scale based on income level. The premium credits will be advanceable and available for purchase of insurance through

the Exchange. In addition to premium credits, cost sharing subsidies will be provided to individuals and households whose income is between 100% - 400% FPL.³

Larger employers (over 50 full-time employees (FTEs)) will be required to offer their employees a qualified health plan or pay a tax penalty. Employers offering health plans will face penalties if one or more of their employees choose to purchase coverage through an Exchange and receives a federal subsidy (under certain conditions). Employers who do not offer coverage will be required to pay \$2,000/FTE (first 30 FTEs are excluded from calculation) if one or more of their employees receive a subsidy through the exchange. Employers who do offer coverage will be required to pay \$2,000/FTE or \$3,000/subsidized employee (whichever is less) if one or more of their employees receive a subsidy.

Small employers (for this provision defined as 25 or fewer employees with average annual wages of less than \$50,000) that purchase health insurance for employees will receive a tax credit of up to 35% of the employer's contribution (25% for non-profit employers) if that contribution is at least 50% of the premium cost for 2010 through 2013. Starting in 2014 the tax credit increases to 50% (35% for non-profits), but then ends two years later. The full tax credits are available for the smallest businesses (10 FTEs or less and average annual wages less than \$25,000) and phases out as business size increases.

Status in Alaska:

- *State Lawsuit Challenging the Individual Mandate: Alaska is participating in the 20-state Florida-led lawsuit against the federal government over the enactment of PPACA. One of the two main complaints asserted in the suit is regarding the federal government's constitutional authority to require individuals to purchase health insurance. The lawsuit was heard in a Florida district court in December, and is expected to proceed to the appellate courts and eventually be heard by the U.S. Supreme Court in 2012 or 2013.*
- *High Risk Pool: The State of Alaska supported and facilitated the application by the state's existing high risk pool, the Alaska Comprehensive Health Insurance Association, for the new federal high risk pool. \$13 million was allocated for Alaska's federally-subsidized pool, and coverage began September 1, 2010. Television and other media have been used to advertise the availability of the subsidized insurance program. 24 Alaskans had enrolled as of December 17.*
- *Early Retiree Reinsurance Program: The following Alaskan employers and unions had been approved for participation in this program by the US DHHS as of December 20: Alaska Electrical Health and Welfare Fund, Alaska Pipe Trades UA Local 367 Health & Security, Alaska Teamster-Employer Welfare Trust, Alaska USA Federal Credit Union, Alyeska Pipeline Service Company, Municipality of Anchorage, State of Alaska Retirement and Benefits Plan, Tongass Timber Trust.*
- *Health Insurance Rate Review: The State of Alaska chose not to apply for the state Health Insurance Rate Review grant made available in July (and again in October) citing onerous grant requirements, lack of state statutory authority to pre-approve health insurance rates for most health insurance plans, and sufficient existing capacity to review health insurance rates. At this date it is unknown whether state legislation will be introduced during the 2011 legislative session to adopt new federal insurance standards in state law.*
- *Consumer Information & Assistance: The State of Alaska chose not to apply for the state Consumer Information and Assistance grant made available in September citing concerns over sustainability of capacity created with one-time funds, and insufficient need (the Alaska Division*

³ The Hyde amendment applies to the use of federal funds in these programs, and prohibits the use of federal subsidy funds for the purchase of coverage for abortion (except in the case of rape or incest or to save the life of the mother).

of Insurance currently has sufficient capacity to respond to consumer inquiries and complaints in its existing consumer assistance program).

- *Health Insurance Exchange: The State of Alaska chose not to apply for the state Health Insurance Exchange planning grant made available in September. At this date it is unknown whether state legislation will be introduced during the 2011 legislative session to establish an Alaska health insurance exchange.*

Title II – Public Health Care Coverage

PPACA changes the role of the Medicaid program in the health care system by moving the program from one that covers certain safety-net populations to one that covers all individuals under certain income limits so that it becomes the floor for all insurance coverage in the country. The law expands Medicaid eligibility to everyone under 65 years of age, including childless adults, whose incomes are under 138% of FPL (the new minimum eligibility level is 133% but PPACA also imposes a required 5% income disregard effectively increasing the level to 138%). A maintenance of effort requirement took effect on enactment of the law in March to prohibit States from reducing eligibility for adults between now and when the expansion takes effect in 2014. The maintenance of effort requirement for children is in place until September 30, 2019.

The federal government will absorb 100% of the increased cost associated with the expansion population during the first four years, then States will begin sharing in the cost at phased in levels until the State share is 10% in 2020. States have the option of expanding eligibility prior to 2014, but would do so at their regular match rate (about 50% for Alaska). Of significance is a policy change in PPACA that requires States to change to a new eligibility determination method based on modified adjusted gross income. A number of new enrollment procedure changes are included as well, along with a requirement for States to integrate Medicaid enrollment into the Health Insurance Exchange.

A number of provisions add new requirements for covered services, such as freestanding birth center and comprehensive tobacco cessation services for pregnant women; and also makes available new State options to add services, such as family planning for low income individuals. Changes are made to certain payments and reimbursements, such as a new prohibition against federal Medicaid payments to States for services related to health care acquired conditions, and a change to the prescription drug rebate. Optional programs to test new payment methodologies include hospital bundled payment and Accountable Care Organization demonstration projects. There are also incentives and options intended to increase home and community based services in lieu of facility-based services for individuals requiring long term care.

Status in Alaska:

- *Medicaid Maintenance of Effort: the Alaska Medicaid program is required to maintain eligibility standards, methods and procedures for adults until January 2014 and for children until October 2019.*
- *Medicaid Expansion:*
 - *As noted above, Alaska is participating in the 20-state Florida-led lawsuit against the federal government over the enactment of PPACA. One of the challenges under the lawsuit is regarding the unfunded federal mandate imposed by the Medicaid expansion.*
 - *Preliminary estimates released by the Alaska Department of Health & Social Services (DHSS) this summer project that the 2014 expansion will cover approximately 30,000 new enrollees^{iv}. The Urban Institute, applying Alaska data to a national model, projects*

the expansion will add between 42,794 to 59,914 new Medicaid enrollees (33,106 – 49,061 of whom will have been previously uninsured)^v.

- *DHSS is not currently planning to apply for the early expansion option.*
- *New Service Requirements: The Alaska Medicaid program previously exercised the option to cover all the services now mandated under provisions enacted in Title II, including freestanding birth centers and comprehensive tobacco cessation services for pregnant women. These changes are not expected to impact Alaska, other than by eliminating the flexibility the state once had to remove these services from the covered services list, and by requiring a new billing methodology for freestanding birth centers.*
- *Maternal, Infant, and Early Childhood Home Visiting Program: The following organizations were awarded grants under this program in 2010:*
 - *AK Department of Health & Social Services (DHSS): \$584,256*
 - *Southcentral Foundation: \$345,000*
 - *Fairbanks Native Association: \$250,000*
 - *Kodiak Area Native Association: \$236,000*
- *Personal Responsibility Education Program (PREP): DHSS was awarded two grants in 2010 totaling \$849,985 under this program, which focuses on fostering healthy relationships and preventing teen pregnancy. DHSS chose not to apply for an abstinence education grant made available under this title as the relatively small amount allocated to Alaska would not fund the grant requirements, a match was required, and the same services will be provided under the PREP program.*
- *Aging & Disability Resource Centers (ADRC): DHSS applied for but did not receive the ADRC grant made available under Title II in 2010.*
- *Money Follows the Person Rebalancing Demonstration: DHSS did not apply for a planning grant made available for this program, and does not intend to apply to participate in the demonstration project (grant application due in January 2011).*
- *Medical Home for Medicaid Enrollees with Chronic Conditions: Federal planning funds for this demonstration project will be made available in January through Medicaid match at the state's pre-ARRA FMAP rate. DHSS has not yet made a decision regarding whether to plan for and participate in this demonstration.*

Title III – Health Care Delivery and Payment Changes

Title III intends to control health care costs and improve quality through a series of delivery system and payment changes driven primarily through the Medicare program. Increases in Medicare costs will be limited by restructuring payments to Medicare Advantage plans, reducing annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers. Providers organized as Accountable Care Organizations will be allowed to participate in cost savings they achieve for the Medicare program as long as they meet certain quality thresholds. The Center for Medicare and Medicaid Innovation is created to test new payment and service delivery models, and the Independent Payment Advisory Board is created to develop proposals for reducing per capita rate of growth in Medicare if spending exceeds target growth rates. The Secretary of HHS is vested with broad authority to implement payment reform models that prove to be effective at improving quality and reducing the rate of cost growth.

Medicare will reduce payments to hospitals for excess preventable hospital readmissions and for hospital-acquired conditions. Bonus payments will be made to hospitals in counties with the lowest

Medicare spending. Medicare will establish a Hospital Value-Based Purchasing Program to pay hospitals based on performance on certain quality measures. Plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers will be developed. A Medicare pilot program to test payment bundling for acute inpatient hospital, physician, outpatient hospital, and post-acute care services for an episode of care that begins three days prior to a hospitalization and ends 30 days following discharge is created. A home health demonstration program intended to prevent hospitalization and improve cost, patient outcomes and satisfaction is also created.

The Medicare Part D “doughnut hole” is phased out starting with a \$250 rebate check provided to all Medicare beneficiaries entering this drug coverage gap in 2010 and phasing down the coinsurance rate until it is eliminated altogether in 2020. A program to strengthen trauma center capacity is created, along with a demonstration program to develop models for regional emergency care systems.

Status in Alaska:

- *MIPPA (Medicare Improvements for Patients & Providers Act) Medicare Outreach: DHSS was awarded \$65,454 for Medicare Outreach to low-income and rural Alaskans.*
- *The only other major provision under Title III known to have taken effect in Alaska during 2010 was the issuance of the \$250 rebate checks to Medicare enrollees in the prescription drug “doughnut hole.” A few of the provisions impacting Medicare reimbursement also began taking effect in 2010.*

Title IV – Prevention and Public Health

Title IV establishes or reauthorizes and funds a series of programs intended to reduce the burden of disease in the population. It establishes the National Prevention, Health Promotion & Public Health Council and a Prevention and Public Health Fund to coordinate and support prevention, wellness, and public health activities. National committees to develop and disseminate recommendations on effectiveness of clinical and community preventive services are authorized.

Medicaid and Medicare coverage of preventive services is expanded. The Fair Labor Standards Act is amended to require employers to provide reasonable break times and private locations for employees who are nursing mothers to express breast milk. Chain restaurants will be required to disclose the nutritional content of the food items they sell.

“Community Transformation” and “Healthy Aging, Living Well” grants aimed at reducing chronic disease rates and addressing health disparities through wellness activities are funded, and a worksite wellness program to provide technical assistance and funding to small businesses is also established. A grant program to support school-based health centers is created. A grant program to support oral health promotion and disease prevention is created. Programs to improve immunization coverage and continue federal support of public health epidemiology and laboratory capacity are authorized or reauthorized.

Status in Alaska:

- *Much of the new funding appropriated to the new National Prevention & Public Health Fund was diverted by the US DHHS to fund workforce programs authorized but not funded under Title V.*
- *The following grants were awarded to the Alaska Division of Public Health under provisions in Title IV during 2010:*

- *Strengthening Public Health Infrastructure (\$100,000)*
- *HIV/AIDS Surveillance – Lab Reporting (\$41,909)*
- *Epidemiology & Laboratory Capacity (\$473,908)*
- *Behavioral Risk Factor Surveillance System Supplemental (\$68,265)*
- *Strengthening Tribal Public Health Infrastructure: The Alaska Native Tribal Health Consortium and the SE Alaska Regional Health Consortium were each awarded \$100,000 under this new program.*
- *School-Based Health Centers Capital Program: None of the three school-based health centers (Juneau-Douglas High School/Juneau, Mt. Edgecumbe High School/Sitka, and Clark Middle School/Anchorage) applied to participate in this 1-year equipment grant opportunity.*

Title V – Health Care Workforce

Title V establishes a National Workforce Advisory Committee and requires a national health care workforce assessment be conducted. There are a number of new scholarship and educational loan repayment programs created and existing programs are expanded, with certain emphases on primary care and preventive specialties, nursing, oral health, public health, geriatrics, and behavioral health. It increases the National Health Services Corps and eliminates the cap on the number of commissioned officers in the Public Health Service Regular Corps, and also expands the use of the Reserve Corps (renamed Ready Reserve Corps) in times of a public health emergency. It also expands Area Health Education Centers.

The number of Medicare-funded physician training positions (Graduate Medical Education (GME) for residency training) will be increased by redistributing unused positions with priority given to primary care and general surgery, and by expanding eligible training sites to allow for outpatient health center-based residency training programs. A number of provisions also support the development of training programs in different patient care models, such as medical homes, chronic disease management, and integration of primary and specialty health care into behavioral health care settings. This Title also includes a provision for a 10% bonus payment under Medicare to primary care physicians and general surgeons practicing in health professional shortage areas.

Status in Alaska:

- *State Health Care Workforce Development: The Alaska Workforce Investment Board (AWIB)/ Department of Labor & Workforce Development (DOLWD) in collaboration with the Alaska Health Workforce Planning Coalition received a \$150,000 grant in September to develop a strategic plan for health workforce development in Alaska.*
- *Health Occupations Training for Low Income and TANF Recipients: DOLWD also collaborated with DHSS to apply for funding for this program but did not receive a grant. The Cook Inlet Tribal Council was awarded \$1,463,627 in September under the tribal organizations provision for this program.*
- *Primary Care Service Integration in Behavioral Health Centers: Alaska Island Community Services (in Wrangell) was awarded a grant of \$296,836 under this program in September.*
- *Primary Care Residency Expansion: This grant opportunity became available in July, but did not support planning and development for new residency programs and therefore was not a potential funding stream for development of the new psychiatric or pediatric residency programs in Alaska. The Alaska Family Medicine Residency Program chose not to apply due to concerns over sustainability as the grant would only support addition of new residency slots for one year.*

- *Physicians Assistant Training Program: The UAA Physicians Assistant Training Program was not eligible to apply under the grant opportunity made available by this program in July (only accredited PA schools were eligible, and the PA program at UAA is accredited under the University of Washington's MEDEX program).*
- *Family-to-Family Health Information Centers: This program, initially created in 2005, was reauthorized under PPACA. Stone Soup Group, an Anchorage-based non-profit, was previously funded under this program and received a continuation grant of \$96,700 in July to provide information and training to families of special needs children.*
- *No Alaskan organizations are known to have applied for the following grant opportunities made available under provisions in Title V during July:*
 - *Personal and Home Care Aide State Training Program (competitive 6-grantee demonstration project)*
 - *Advanced Nursing Education Expansion Program*
 - *Nurse Managed Health Clinics*
 - *Nursing Assistant and Home Health Aide Program*

Title VI – Fraud, Waste and Abuse

Title VI will require transparency related to financial relationships between health care provider and supplier entities. New provider enrollment processes for Medicare and Medicaid are created, as well as a new database for sharing provider data among federal programs and between federal and State programs. Providers and suppliers will be required to establish compliance programs, and face increased penalties for false claims. State Medicaid programs are required to implement the Medicare RAC (Recovery Audit Contractor) Program.

The Elder Justice Act is created under this title, which addresses prevention and intervention in the abuse and neglect of individuals aged 60 or older, creating an Elder Justice Coordinating Council, and providing funding to State Adult Protective Services and Long Term Care Ombudsman programs. A medical malpractice demonstration program is also created, which will provide grants to States to test alternatives to tort litigation. This title also establishes a non-profit Patient-Centered Outcomes Research Institute to identify priorities for a national comparative outcomes research project agenda.

Status in Alaska:

- *Medicare RAC Program Expanded to Medicaid: AK DHSS submitted a request to US DHHS to extend the deadline for Alaska's compliance with this new requirement from April 1, 2011 to October 1, 2011. The department currently has a contract in place with Myers and Stauffer to conduct audits of Medicaid providers required under state law (AS 47.05.200). This contract is up for annual renewal 10-1-11. The department's intent is to align the state audit program as much as possible with the new RAC program. It will not be possible however to fully integrate the two Medicaid audit programs, as the state program pays the audit contractor a flat fee, while the federal RAC program requires audit contractors be paid on a contingency fee basis.*
- *Nationwide Program for Long Term Care Worker Background Checks: The DHSS/Division of Public Health's Section of Certification & Licensing received a grant of \$1 million in October under this program.*
- *Other Provisions: Additional changes enacted under this Title that will potentially impact the Alaska's Medicaid program are currently under analysis by DHSS, including extension of the*

period for collection of overpayments, termination of provider participation in Medicaid if terminated under Medicare, and required participation in the National Correct Coding Initiative.

Title VII - Pharmaceuticals

Title VII authorizes the FDA to approve generic versions of biologic drugs, and expands the 340B program, which is a program limiting the cost of covered outpatient drugs to certain federal grantees.

Status in Alaska:

- *Unknown*

Title VIII – CLASS Act

The Community Living Assistance Services and Supports Act will establish a national, voluntary long term care insurance program starting in 2011. The program requires five-year vesting, and will provide a cash benefit of no less than \$50 per day to help aged or disabled individuals to stay in their home. The benefit may also be used to cover nursing home costs. Premiums will be paid through payroll deductions.

Status in Alaska:

- *The federal government is required to establish this new national program in 2011.*

Title IX – Taxes and Fees

New taxes and fees imposed in order to finance the new programs established under PPACA started in 2010 with a 10% excise tax on indoor tanning. There are a series of new taxes and fees imposed on the health care industry and health care products, such as an annual fee on the pharmaceutical industry (starting at \$2.8 billion in 2012 and increasing over time), an annual fee on the health insurance industry (starting at \$8 billion in 2014 and increasing over time), and a 2.3% sales tax on medical devices starting in 2013. The tax deduction for employers receiving Medicare Part D retiree subsidies is eliminated.

The Medicare payroll tax is increased starting in 2013 by 0.9% (from 1.45% to 2.35%) for individuals who make over \$200,000/year (\$250,000/year for married couples filing jointly). The payroll tax increase applies only to the employee, not the employer share of the tax. There is also a new 3.8% tax imposed on the unearned income for high-income individuals in that same tax bracket. The revenue from that tax is intended to flow to the Medicare program. Starting in 2018 a new excise tax will be imposed on employer-sponsored high-value insurance plans. Otherwise known as the “Cadillac tax”, this tax will be imposed on plans valued at more than \$10,200 for individual plans and \$27,500 for family coverage, and will be assessed at 40% of the amount over those thresholds.

Status in Alaska:

- *The one Title IX provision that took effect in 2010 was the new federal 10% sales tax on indoor tanning.*

Title X - Amendments

There are a few stand-alone provisions included in Title X (not amending other sections of PPACA). Of significance to Alaska's health care system is a provision that expands funding for Community Health Centers and another that permanently reauthorizes the Indian Health Care Improvement Act. There is one provision specific to Alaska that created the Federal Interagency Task Force to Improve Access to Health Care in Alaska, which was charged with assessing access to health care for beneficiaries of federal health care systems in Alaska.

Status in Alaska:

- *Federal Interagency Task Force to Improve Access to Health Care in Alaska: The Task Force was convened in July, conducted a site visit in August, and issued its report and disbanded in September. A copy of the Task Force's report is available on the Commission's website.*
- *Community Health Center Construction/Renovation: Two Alaska CHCs received grants in October in the first round of funding made available under this program – the Anchorage Neighborhood Health Center (\$8 million) and the SE Alaska Regional Health Consortium (\$1,299,147).*
- *The Alaska Native Health Board sponsored workshops during 2010 for its member tribal health care organizations and partners on changes made under the Indian Health Care Improvement Act reauthorization and associated amendments.*

Economic Impact of the Federal Affordable Care Act (ACA) on Alaska

Executive Summary of October 2010 Presentation to Commission (included in Appendix C), by Mark A. Foster & Associates/Institute for Social & Economic Research.

Overview – How much might it cost by 2019?

- The Medicaid Expansion and Individual Mandate may result in a *net* increase of roughly 60,000 insured individuals in Alaska by 2019; reducing the number of uninsured by about 50% over baseline projections
- The *net effect on overall Alaska health care spending* in 2019 may be an increase of roughly 3%, consisting of:
 - An increase of roughly 4% associated with an increase in utilization of medical care by the newly insured and those whose existing insurance coverage will be increased to comply with new requirements
 - An increase to close the Medicare prescription drug "donut hole"
 - Decreases associated with:
 - Medicare reductions in allowable growth rates – including hospitals, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, hospice, and home health
 - Insurance and provider discounts imposed or negotiated
 - Reductions in utilization associated with the shift of financial resources away from health insurance and toward income in response to the 40% excise tax on high cost plans

Changes in Funding Sources in Alaska, 2019 – Who Pays?

- Federal support for the Medicaid Expansion *and* subsidies for households <400% of federal poverty level (FPL) are the primary sources of funding for the insurance expansion – totaling roughly \$800 million in Alaska in 2019
- The increased federal support for the insurance expansions will be offset by:
 - Reductions in the overall level of spending on Medicare including:
 - Increments for closing the Medicare prescription drug benefit “donut hole” [<\$10M], and
 - Decrements associated with reductions in rate updates and changes in payments for hospitals, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, hospice, and home health [\$60M]
 - Increased Medicare taxes on high income families [\$90M]
 - New 40% excise tax on high cost health plans (approx 50% of health plans in Alaska in 2019 may be subject to the excise tax) [\$280M]
 - New fees on drugs, medical devices, health insurance, changes in tax deductions and Health Savings Accounts (HSA) rules [\$80M]

Impact on Households

In aggregate, Alaskan households may spend on the order of 1-2% more on health care, which is the net effect of several factors including:

- Subsidies
 - Federal support of coverage expansions – including insurance premium support, cost sharing subsidies, and Medicaid expansion
- Insurance Mandate
 - Increased costs for households who purchase insurance to comply with the mandate; even after subsidies and cost support, households can be expected to pay on the order of 8-9% of income on health insurance
 - Penalties of 2.5% of income for households who decline to purchase health insurance
- Taxes and Fees
 - 40% excise tax on high cost health plans
 - New fees on drugs, medical devices, health insurance providers, changes in tax deductions and Health Savings Accounts rules

The net effect of the ACA on households varies considerably by income level, whether previously insured, and the age of householder. Low and moderate-income level older households and high medical expense households tend to be net beneficiaries. Healthier, higher-income households with no insurance or high deductible plans tend to be net payers. Previously insured households <400% of federal poverty guidelines (\$110,280 for a family of four in 2010) are slated to receive insurance subsidies that increase as household incomes decrease. With some limited exceptions, uninsured households above 138% of federal poverty level can be expected to spend roughly 8-9% of their income (after subsidies) to purchase health insurance or spend up to 2.5% of their income as a penalty for noncompliance with the individual mandate. In the individual and small group market, young singles (not covered under their parents’ plans) and young families can expect to pay more under health insurance reform while those over 55 can expect to pay less due to a mandate to limit age differentials (previously market rates for insurance tended to more closely track the actuarial costs by age group).

Impact on Private Business

In aggregate, Alaskan businesses may see a reduction in spending on health care of around 3%, which is the net effect of several factors including:

- A reduction in the number of firms offering health insurance with employees migrating to the new Exchange for subsidized coverage; sign-up rates in the new Exchange are likely to be higher for low to moderate wage employees (<400% of FPL) who are in line to receive larger subsidies as a portion of their income in the Exchange
- Firms with 50 or more employees may offer insurance or be required to pay an assessment when their employees use subsidies in the new Exchange

Impact on key economic sector competitiveness

Resource development and export sectors with high wages and benefits appear likely to experience the 40% excise tax on high cost plans sooner than their competitors in other states. Large fishing and tourism enterprises may be faced with challenging “pay or play” penalties due to the high cost of medical care. Small fishing and tourism enterprises may not see the same proportion of small business tax credits due to a relatively small proportion of employees with “low wages” as compared to other states.

C. Issues Prioritized for Study in 2011

1. Health Care Costs

Health care costs are higher in Alaska compared to other states^{vi}, but a thorough understanding of the underlying reasons why costs vary is required prior to making specific policy recommendations to address the problem. Is it due to an insufficient supply of providers and insufficient competition between providers? Is there higher utilization of medical services in our state, and if so is it due to waste in the system or due to a higher prevalence of complex health conditions? How does fragmentation of the health care delivery system affect overall costs? Are payers unable or unwilling to negotiate the lowest possible price for services?

An important aspect of understanding variations in cost and underlying cost drivers is understanding how cost shifting occurs when one payer or set of payers underpays a health care provider (pays less than the costs the provider incurs to deliver the service). Prices charged are typically higher than the cost of care to make up for capped reimbursement by some payers, low fees negotiated with contract payers, and uncompensated care provided for uninsured and underinsured individuals who are unable to pay. Further analysis of cost drivers and cost shifting is needed to support development and implementation of successful strategies to control cost and improve value.

The high and continued escalation in health care costs in Alaska was a primary concern of the Commission in 2009, and they identified the need for additional analysis to better understand what is driving those costs as a top priority for future study. To understand the main variables influencing cost the Commission was introduced to this simple formula in 2009:

$$\text{Cost (total spending)} = \text{Price (paid)/process unit} \times \text{Utilization}$$

During 2010 they were introduced to a more detailed breakdown of the utilization variable:

$$\begin{aligned} \text{Utilization} = & \\ & \# \text{ of health conditions} \\ & \times \# \text{ of episodes of care/condition} \\ & \times \# \text{ of services (by type)/episode of care} \\ & \times \# \text{ of process units/service} \end{aligned}$$

This formula is providing a framework to guide plans for studying the cost of health care in 2011.

A. Health Care Spending and Cost Driver Analysis – In order to better understand the current cost of health care in Alaska in terms of total spending in the state for health care services the Commission has contracted with the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage to conduct an analysis. ISER conducted similar analyses in the past – once in 1992 and more recently in 2005 (published in March 2006 with 2005 data).^{vii} ISER will provide updated information on current spending by payer and service category, will expand past analyses of cost drivers, and will also include an analysis of opportunity costs of high health spending. The final report, expected in April 2011, will include:

- A review of historical spending trends, health insurance and health provider costs, and distribution of public and private payers;
- A ten-year spending forecast;

- An analysis of cost drivers, including:
 - Demand
 - Demographic trends
 - Technology
 - Nature and extent of insurance coverage
 - Tax treatment of benefits
 - Supply sensitive and preference sensitive demand considerations
 - Supply
 - Inefficient organization
 - Physician supply
 - Other factors (e.g., institutional factors, research)
- An analysis of opportunity costs of health spending (in Alaska and compared to the U.S.), including health spending trends as a percentage of GDP compared to other sectors, implications of health spending trends in terms of potential cuts to other public programs and/or tax increases, and description of what higher spending in Alaska buys.

B. Health Care Price and Reimbursement Study - The Commission will contract with a health care actuarial consulting firm with expertise in the analysis of system-wide health care pricing and reimbursement to conduct a study comparing health care provider third party and private-pay charges and reimbursement in Alaska to charges and reimbursement for the same services in Washington and Oregon, and to also benchmark those charges against public coverage such as Medicare, Medicaid, Workers Compensation, TriCare, and the Veteran's Administration. Specific analyses to be requested will include:

- Comparisons of billed and allowed non-facility provider charges, on a per unit basis, for the top 25 most commonly used codes;
- Comparisons of billed and allowed non-facility provider charges, on a per unit basis, for the top 25 most commonly used codes by specific major specialties, including but not limited to family practice, pediatrics, internal medicine, ob/gyn, orthopedics, urology, gastroenterology, cardiology, neurology, general surgery, cardiothoracic surgery, interventional cardiology, ENT, ophthalmology, diagnostic imaging, and chiropractic;
- Comparisons of facility-based provider charges.

The range of billed and allowed charges for each grouping of codes by specialty, as well as the mean and the 50th and 80th percentile, will be included. The consultant will also be asked to identify the major drivers of the pricing and reimbursement differences between Alaska and the other states.

In addition, to assist the Commission in better understanding the challenges Alaska physicians face in delivering Medicare services under the current reimbursement structure, the consultant will be asked to include an analysis of variations in the cost of providing primary care (including compensation, materials and overhead) to Medicare recipients in Alaska compared to other regions of the study, and a description of the major factors driving differences resulting in under-reimbursement of Alaskan physicians by the Medicare program.

The Commission intends to award this contract in January 2011 and hopes to take delivery of the final report by July 2011.

C. Health Status Assessment - The Commission is interested in learning how the “health conditions” variable in the cost equation is driving utilization of and spending for health care services, and has asked the Department of Health & Social Services to provide information on the health status of the Alaskan population, including health trends and health disparities, with comparisons to national averages. The Commission anticipates the information will include data on chronic and infectious disease, injury (both intentional and unintentional), health risk behaviors (including substance abuse), mental illness, and disabling conditions. The Commission hopes to receive the state health status report by July 2011.

3. Long Term Care

Alaska’s long term care system is recognized as being one of the most balanced in the nation in terms of supporting people to live in their home and in community settings as opposed to institutions. However, the growing cost of providing long term care services is a critical issue facing Alaska’s Medicaid program, and Alaska’s senior population is projected to triple over the next twenty years. Current challenges in addition to escalating costs and concerns over system capacity include the need to improve quality in assisted living and other home and community based services, and inadequate services for individuals with maladaptive or severe behavior issues. During 2011 the Commission will compile recent long term care studies, plans and other information available, and will invite a presentation by state leaders grappling with the long term care challenges in our state.

4. Trauma System

Injury is the leading cause of death for Alaskans who are one to 44 years of age. A trauma system that provides rapid appropriate response and treatment is critical to reducing death and disability due to injury. The Department of Health & Social Services made trauma system development a priority two years ago and commissioned a study by the American College of Surgeons Committee on Trauma. Progress has been made since the release of the Committee’s November 2008 report. For example HB 168, establishing the Uncompensated Trauma Care Fund to incentivize hospitals to meet trauma center standards, passed during the 2010 legislative session and was signed into law in June; and, DHSS created and filled a Trauma System Coordinator position to support development of a trauma system strategic plan. During 2011 the Commission will learn about the status of trauma system improvement in our state.

Part III: Alaska Health Care System Transformation Strategies

A. Status of Implementation of 2009 Commission Recommendations

The Commission intends their recommendations from prior years to continue standing as current recommendations unless and until they decide to modify or eliminate them based on further study. To that end the Commission will track, consider and report on implementation of our prior year recommendations over time. During 2010 progress was made related to all of the 2009 Commission recommendations. Following is a summary of these developments.

A. Strengthen the Consumer's Role in Health and Health Care

1. Support healthy lifestyles and create cultures of wellness
2. Develop patient-centered primary care models through payment reform, removal of barriers, and support for pilot projects

Healthy Lifestyles

State agencies operate a number of programs aimed at supporting healthy lifestyles, including programs to prevent and control specific diseases and conditions and also risk behaviors such as: obesity, tobacco use, alcohol & drug abuse (including Fetal Alcohol Spectrum Disorders), suicide, unintentional injuries, domestic violence & sexual assault, child abuse, infectious disease, chronic disease, autism, and metabolic and other genetic disorders. Following are significant new efforts initiated and resources invested during 2010.

- Governor Parnell launched “Choose Respect” in March 2010, a new initiative to stop the epidemic of domestic violence and sexual assault in Alaska. As an early phase of this initiative, the Governor proposed and won passage of several new laws during the 2010 legislative session targeted at sexual and domestic violence offenders. The Governor’s initiative is now aiming to prevent domestic violence and sexual assault from occurring in the first place by working towards creating a culture that emphasizes respect for others and zero tolerance of violence against women and children.
- The Alaska Department of Health & Social Services (DHSS) implemented two new initiatives related to obesity and chronic disease prevention and control:
 - Alaskans Taking on Childhood Obesity: DHSS collaborated with the Alaska Department of Education & Early Development (DEED) to create “ATCO” – a Task Force convened by the Commissioners of the two state agencies and including the Anchorage School District, Alaska Association of School Boards, and the Alaska Native Tribal Health Consortium to develop recommendations regarding strategies to reverse the trend of increasing rates of overweight and obesity among Alaska’s children. The two state agencies (DHSS and DEED) formalized their agreement to collaborate in school-based obesity prevention and reduction efforts in a Memorandum of Agreement signed by Commissioner Hogan and Commissioner LeDoux in July.
 - Alaska Food Policy Council (AFPC): DHSS collaborated with the Alaska Division of Agriculture, US Department of Agriculture, Farm Bureau, Alaska Center for the Environment, and Alaska Root Sellers to create the first food policy council in Alaska. The goal of the new council is to expand

Alaska's food production, improve supply and distribution of locally grown and produced products, decrease hunger, support the use of traditional and local foods, and increase nutrition literacy of consumers.

- DHSS also received an annual operating budget increase of \$375,000 in state general funds in the SFY 11 budget to support the Division of Public Health's Obesity Prevention & Control Program. The new state funding will not support new efforts, but replaces federal funding received through hard earmarks and under ARRA to support obesity prevention and control over the past decade. Without the new state funds and with federal support drying up the program may have been discontinued.
- The Statewide Suicide Prevention Council launched a new web portal in November, www.StopSuicideAlaska.org, offering information and resources for individuals and groups in Alaska to support efforts to prevent suicide and help with recovery after a loss.

Patient-Centered Primary Care

During 2010 DHSS received a federal grant under CHIPRA (Children's Health Insurance Program Reauthorization Act) that will provide funding for piloting and evaluating patient-centered medical home care models to improve children's health care in primary care clinics in Alaska. The department released a grant Request for Proposals in November and intends to make grant awards to pilot sites in January 2011.

In June of this year the Southcentral Foundation's (SCF) Primary Care Center became the first practice in Alaska to achieve NCQA (National Committee for Quality Assurance) recognition as a patient-centered medical home (level III; effective 2010-2013). In July the University of Alaska Anchorage was awarded a 2-year federal grant to evaluate SCF's adoption of the medical home model in terms of its impact on the cost and quality of care.

This past year the Providence Family Medicine Center/Alaska Family Medicine Residency Program transitioned to a patient-centered medical home care model. The new Providence Senior Care Center, scheduled to open in January 2011, is building its practice based on the same model.

The Alaska Primary Care Association (APCA) launched an initiative in 2010 to support their members' efforts to transform their clinics and practices to a medical home model. APCA contracted with Primary Care Development Corporation to hold a learning session for member clinics and organizations on how to become a recognized medical home. APCA is currently investigating opportunities for developing a set of "Alaskanized" patient-centered medical home standards that will be based on national standards but modified to accommodate special features of health care delivery in Alaska (such as mid-level practitioner led clinics in rural communities too small to support physician practices).

B. Foster Statewide Leadership to Support Health Care Transformation

1. Invest in the health policy infrastructure needed to respond to national reform
2. Establish a permanent state health planning and policy body in statute

National Reform

Following passage of the federal health care reform laws in March and April Governor Parnell directed the State Attorney General to join the Florida-led multi-state lawsuit challenging the law on two primary points: 1) the constitutionality of the federal government's authority to require individuals to purchase

health insurance or pay a penalty, and 2) the imposition of an unfunded mandate on state government by expansion of the Medicaid program.

Due to the Administration's constitutional challenge to the new federal laws, state agencies are proceeding cautiously regarding implementation of new programs created by the laws. State agency staff have been working to assess requirements imposed on state government and to consider options to participate in potential funding opportunities. Decisions to participate in optional programs and regarding how to implement required provisions are being made on a case-by-case basis by program managers and agency executives based on alignment with current policies and programs.

Information that has been made public to-date by state and federal agencies on analyses and implementation of the new laws in Alaska is included in this report in Part II.B and Appendix B.

State Health Planning & Policy Body

The Alaska Legislature passed SB 172 establishing the Alaska Health Care Commission in statute on the final day of the legislative session in April. The bill was transmitted to the Governor in June and signed into law June 21. The new law is very similar to Governor Palin's order that established the original Commission (Administrative Order #246). The most substantive change is the addition of four new voting member seats. SB 172 also included a transition clause to automatically appoint former members appointed under A.O. #246 to the new Commission. New Commission members were appointed September 15 and the Commission convened for the first time in October of this year.

C. Develop the Health Care Workforce

1. Make workforce a priority on health care reform and economic development agendas
2. Strengthen the pipeline of future health care workers
3. Support workforce innovation and adaptation as patient care models evolve
4. Direct workforce planning to be more coordinated
5. Increase the supply of primary care physicians by
 - Supporting educational loan repayment and financial incentives for recruitment
 - Expanding the WWAMI Alaska medical school program as resources allow
 - Supporting primary care residency program development and operation

Health Workforce Planning

The Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan," which was adopted by the Alaska Workforce Investment Board in May 2010. In September the Department of Labor & Workforce Development (DOLWD) received a federal grant to develop a strategic plan for health workforce development in Alaska. DOLWD is using these funds to support the work of the Coalition to develop an action plan based on the new comprehensive statewide plan. The Coalition anticipates the action plan will be drafted by the spring of 2011. The Coalition also launched a new website this year (<https://sites.google.com/site/alaskahealthworkforcecoalition/>) and has been holding monthly planning meetings.

Educational Loan Repayment & Financial Incentives

A number of bills introduced in the 26th legislature (2009-2010) would have created and funded a state educational loan repayment and financial incentive program to support recruitment of health care professionals to serve underserved areas and populations in Alaska, but none of these bills passed.

During 2010 the Department of Health & Social Services started a loan repayment program, SHARP (Supporting Healthcare Access through loan Re-Payment), funded with a 1-year \$600,000 federal grant and additional funds provided by the Alaska Mental Health Trust Authority and health care organizations. The annual loan repayment benefit provides up to \$35,000 for Tier-1 professions or \$20,000 for Tier-2 professions for two years, and is paid directly to the practitioner's lender. Eligible practitioners are primary care physicians, nurse practitioners, physician's assistants, dentists, dental hygienists, psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, licensed professional counselors, and marriage and family therapists serving in identified high-needs areas and facilities. The first grants issued under this program were awarded in June to 14 practitioners based in Anchorage, Bethel, Dillingham, Kenai, Homer, Petersburg, Talkeetna, Tok and Wrangell, as follows: \$230,000 to five behavioral health providers, \$140,000 to two dental care providers, and \$361,771 to seven primary medical care providers.

Primary Care Residency Programs

Of the three new residency programs noted as a need in the Commission's 2009 recommendations, there was significant progress made related to planning and development for two during 2010:

- Alaska Pediatric Residency: The new pediatric residency program will be a three-year branch program of the UW Children's Hospital Pediatric Residency Program. Residents will complete a four-month rotation in Alaska during each of the three years in training; will train in Anchorage, Fairbanks and Juneau; and will have opportunities for placement in both urban and rural and tribal health system and private industry sites. The new pediatric residency program will support 12 residents starting in 2012. Planners do not anticipate requesting funding from the State of Alaska for support. Financial support will be provided by Southcentral Foundation, Providence Health and Services System, Banner Health System, SouthEast Alaska Regional Health Consortium, and the Seattle Children's Hospital.
- Alaska Psychiatry Residency: The new psychiatry residency program will be a four-year branch program of the University of Washington Psychiatry Residency Program. Residents will spend their first two years training in Seattle, and the last two years in Alaska. The program could begin as early as the summer of 2012, and at full capacity 11 residents will be enrolled in the program each year. Residents will train with both urban and rural providers of psychiatric care, and their training will emphasize primary care integration, telepsychiatry and rural/remote consultation. Financial support will be provided by Southcentral Foundation, Anchorage Community Mental Health Trust, Fairbanks Memorial Hospital, Providence Health and Services System, and the Alaska Psychiatric Foundation. Planners anticipate requiring State of Alaska funding in addition to industry and other support to start and maintain operation of this program.

D. Deploy Health Information Technology

1. Support health information technology adoption and utilization
2. Ensure public health connectivity
3. Ensure resulting information is used for optimization of medical care
4. Ensure privacy and security
5. Facilitate broadband telecommunications service access
6. Improve reimbursement for telemedicine

In April 2010 the Alaska Department of Health & Social Services awarded a \$3 million four-year contract to the Alaska eHealth Network (AeHN) to serve as the state's official Health Information Exchange (HIE) management entity. In November AeHN awarded a contract to Orion Health to provide the technology for Alaska's statewide exchange. Initial pilots to begin connecting hospitals and clinics in certain test sites are slated to begin in April 2011. The program creates a system for securely moving electronic health records (EHRs) between participating health care providers; provides connectivity to referral providers in Alaska and the lower 48; supports telemedicine (high-resolution image transfer, videoconferencing, and Voice-over-Internet applications); and creates a system to track chronic disease across the state, coordinate care programs and improve patient health.

Also in April AeHN received a federal grant of \$3,632,357 to establish a Regional Health IT Support Center (also known as the Regional Extension Center, or "REC") to provide technical assistance to health care providers in the selection and implementation of EHRs. One of AeHN's goals is to assist smaller providers with implementing EHR systems and achieving "meaningful use" (standards for qualifying for incentive payments and avoiding penalties). Services include EHR readiness assessment, vendor selection and contracting assistance, practice workflow redesign, training, and IT support ("geek team"). Alaska's REC began offering services in September.

Following a 2009 survey of Alaskan providers on EHR adoption that identified difficulty in selecting an EHR vendor as a top barrier, the Alaska EHR Alliance launched an 8-month process to select two EHR vendors to endorse for Alaska's providers. In April 2010 the Alliance selected e-MDs and Greenway Medical Technologies as the preferred vendors. Under the endorsement Alaska providers are offered reduced pricing and access to pre-negotiated contracts to simplify the EHR selection process, in addition to the assurance that the vendors were carefully vetted from an initial field of 250 potential vendors by a team of Alaska health care system stakeholders. This project was funded by AeHN through a grant from the State of Alaska.

The Alaska EHR Alliance also updated their 2009 survey of Alaskan providers in January 2010 by contacting clinics that reported not having EHRs in the 2009 survey. Of the 94 clinics that responded to the follow-up survey, 24 had acquired new EHRs in the past year and an additional 18 were planning to do so.

In addition to the contracts negotiated by the Alliance with e-MDs and Greenway, two Alaska hospitals began offering EHRs at a reduced price to affiliated physicians this year. Central Peninsula Hospital in Soldotna offers eClinical Works and Providence offers Epic as remote-hosted EHRs, providing hosting, maintenance and subsidies to independent physician practices choosing to adopt their systems.

The University of Alaska partnered with Dakota State University this year to create Alaska's first Health Information Technology Workforce Training Program. The program offers two certificates available through the UAS Sitka Campus providing noncredit continuing education courses via online delivery. The two certificates, one for Health IT Redesign, Planning, and Management, and the other for Health IT Implementation and Technical Support, fulfill the requirements for roles defined by the federal Office of the National Coordinator (ONC) for Health IT. This program is federally funded by the American Recovery and Reinvestment Act of 2009 (ARRA).

In July CMS published final regulations to implement the Medicare and Medicaid EHR Incentive Programs created by ARRA. These programs will begin providing financial incentives to health care providers making "meaningful use" of electronic health records in 2011. Federal regulations also issued

in July implement the EHR Certification Program. Authorized testing and certification bodies are now certifying EHR technologies as meeting compliance standards required for achieving meaningful use.

Significant 2010 developments related to expansion of broadband availability and support in Alaska include:

- The creation of Connect Alaska at the beginning of the year. Connect Alaska is a subsidiary non-profit of Connected Nation (a national non-profit formed to expand broadband across the U.S.), and received a \$1.9 million federal NTIA (National Telecommunications and Information Administration) grant through the Denali Commission to map broadband connectivity in Alaska.
- The launch of Alaska's first statewide broadband availability map in September. Connect Alaska, in partnership with the Alaska Department of Commerce, Community and Economic Development, developed the web-based interactive map with funding from the federal NTIA grant (appropriated under ARRA). The map will be continually updated, and is available at www.connectak.org.
- Receipt of \$117 million in federal grants and loans by broadband service providers to expand and improve broadband connectivity to rural SW Alaska communities (and also Tanana and Cordova).
- Receipt by 257 health clinics in rural Alaska of FCC subsidies for telecommunication and internet access costs.

E. Improve Access to Primary Care for Medicare Beneficiaries

1. Increase the supply of primary care providers
2. Support Federally Qualified Health Centers and Rural Health Clinics
3. Request relief from federal reimbursement inequities and administrative burdens
4. Develop a PACE (Program of All-Inclusive Care for the Elderly) program

Expansion of clinical capacity intended to help alleviate the primary care access problem for Medicare beneficiaries is the main area of progress during 2010 related to the Commission's recommendations. One new clinic that accepts Medicare patients opened this year, and two new clinics were planned during 2010 and will open in early 2011:

- Mat-Su Community Medicine, currently staffed by one physician who is board certified in both pediatrics and internal medicine, opened in November. The new clinic accepts Medicare patients, and is being subsidized by Mat-Su Regional Medical Center.
- Providence Senior Care Center will open in January 2011. It will initially be staffed by two internal medicine physicians and one nurse practitioner with hopes to add two additional internists by the summer. Care delivery will be based on the patient-centered medical home model. The Center will accept patients 55 years of age and older, and estimates that approximately 70% of the patients will be Medicare enrollees. Providence Health & Services is subsidizing the start-up and operation of this clinic.
- Alaska Medicare Clinic, Inc., a new non-profit, received a \$1 million state grant in the FY 2011 capital budget to support start-up costs for a new clinic devoted solely to Medicare enrollees. This clinic will be directed by a physician and primarily staffed with mid-level practitioners, nurses and medical assistants. It will not use a patient-centered medical home care model, but planners have developed a streamlined care delivery process. Administrative operations will also be streamlined since the practice will be limited to a single payer and a specific patient population. Clinic organizers are hoping to open in February.

In addition to these new clinics the Anchorage Neighborhood Health Center (ANHC), a Federally Qualified Health Center, is implementing a project to relocate and expand clinic capacity from 20,000 ft² to 42,000 ft². During 2010 ANHC received a new \$6 million state capital grant (in addition to \$10 million in state capital funds received in prior year budgets), and also an \$8 million federal grant under the Patient Protection & Affordable Care Act (PPACA), to support this \$28 million project. The new facility will have 3 medical pods, one dedicated to seniors, and use a patient-centered medical home model. August 2012 is the scheduled move-in date for the new facility.

Health care organizations in Anchorage are continuing to study the feasibility of creating a PACE program, but are not yet prepared to begin active planning with the Department of Health & Social Services on a reimbursement model, which will be the next step towards development of a CMS waiver to develop a PACE program for Alaska.

Individuals commenting at recent public hearings of the Commission have noted a provision included in the federal Patient Protection & Affordable Care Act through an amendment offered by Sen. Begich that intends to provide state governments an avenue for subsidizing Medicare payments to providers with state-funded grants (P.L. 111-148, Sec. 5606 added by Sec. 10501). It is unclear whether this provision overcomes the legal restriction prohibiting providers from accepting supplemental payment for Medicare services.

Continuing Work Needed on 2009 Recommendations

While progress has been made during 2010 in every area the 2009 Commission addressed more effort is needed to implement the initial set of recommendations, including on-going work to:

- Develop policies and capacity to encourage and support healthy lifestyles;
- Foster the development of innovative patient-centered primary care models including integration of primary medical care and behavioral health services;
- Track implementation of federal health reform legislation;
- Create sustainable capacity for health workforce planning and development;
- Improve health professions recruitment and retention through a state educational loan repayment and financial incentive program;
- Develop and support graduate medical education programs for training psychiatry, pediatric, and internal medicine residents in Alaska;
- Support health information technology deployment; and,
- Achieve improvements in federal Medicare policies.

The Commission will continue tracking progress made on the 2009 recommendations and will periodically review and potentially refine and add to these recommendations over time.

B. 2010 Commission Recommendations

Note: The numbering system for Strategies, Findings, and Recommendations continues from 2009.

A.3. Consumer's Role/Value: Foster the use of Evidence-Based Medicine

Finding A.3.a: Waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending.

Finding A.3.b: Evidence-based medicine can increase the effectiveness of medical treatment, improve the quality of health care, and reduce health care costs.

Finding A.3.c: Public and private health care sectors have demonstrated an increasing interest in applying evidence-based medicine to policy and practice in response to high and rising costs and variations in quality of health care.

Finding A.3.d: Involvement of health care providers and patients in decision-making is essential to the successful application of evidence-based medicine to clinical practice and public and private payer policies.

Finding A.3.e: Existing mechanisms to assess patients' compliance with evidence-based medical recommendations are limited.

Finding A.3.f: Assessing the outcomes of health care interventions is challenging due to limitations on collecting and sharing data among patients, clinicians, payers, and government agencies.

"Evidence-based medicine is the practice of medicine in which the physician finds, assesses, and implements methods of diagnosis and treatment on the basis of the best available current research, their clinical expertise, and the needs and preferences of the patient."

Mosby's Medical Dictionary, 8th edition, 2009 Elsevier

Health care expenditures are consuming an increasing proportion of Alaska's and the United States' gross domestic product (GDP) each year, but there is no indication that higher spending is producing better health outcomes for individuals or populations. Furthermore, there is growing evidence that a significant proportion of health care delivered in the United States is ineffective, inappropriate, or unnecessary, potentially wasting hundreds of billions of dollars. An oft-cited estimate is that waste in the health care system due to misused medical resources represents as much as 30% of health care spending. There is a costly gap between the care patients need and the care they actually receive.^{viii}

Highlighting the problem of inconsistent and inappropriate use of health services is the Dartmouth Atlas of Health Care^{ix} and numerous other studies, which have consistently demonstrated wide variations in practice patterns across geographic regions of the United States. The tests and treatment patients receive varies based on the location in the country where the care is provided. Moreover, research has documented those regions of the country where there is overuse of health care resources and higher spending actually have lower quality of care and worse health outcomes.^{x xi xii}

Coinciding with increased recognition of the gap in the quality of care is an evolution in the nature of medical practice toward shared decision-making. A generation ago patients typically relied on their physician to make decisions for them regarding their care. The physician would determine the best

course of treatment based on their training, continuing education and journal reviews, and clinical experience. Today health care decision making is becoming a shared process that includes the provider's clinical judgment but also takes account of the patient's personal values and preferences and presents them with choices based on the best available scientific evidence of what course of treatment might work best for them.

A growing trend in clinical practice that is demonstrating improvement in quality and cost of care and that also supports better patient engagement in decision-making about their care is "evidence-based medicine." Evidence-based medicine (EBM) is a model of clinical practice intended to improve the quality, safety and effectiveness of care by applying scientific evidence of effectiveness and benefit to individual medical decisions. It uses the best available, high-grade evidence to support the clinician's and patient's decision-making process.

The practice of EBM dates back to ancient times, with accounts of efforts to study and understand the health outcomes of different treatment regimens found from Ancient Greece and China and even documented in the Bible.^{xiii} Archie Cochrane, a physician and epidemiologist from Scotland, is acknowledged as the father of modern EBM. His 1972 text "Effectiveness and Efficiency: Random Reflections on Health Services" is noted as having had a profound influence on the practice of medicine and on the evaluation of medical interventions. His work led to the founding of the Cochrane Collaboration which is an international, nonprofit, independent organization dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide.

The term "evidence-based medicine" is relatively new. It came into use in the early 1990s and was first formally defined by David Sackett in 1996 as "the conscientious and judicious use of current best evidence from clinical care research in the management of individual patients."^{xiv} More recently David Eddy integrated the definition to include application of evidence to policy development with his definition published in 2005, defining EBM as a set of principles and methods intended to ensure that, to the greatest extent possible, population-based policies and individual medical decisions are consistent with evidence of effectiveness and benefit.^{xv}

Numerous public and private organizations have demonstrated increasing interest in supporting the use of evidence-based medicine to improve health care quality and contain costs, for example:

- The Blue Cross Blue Shield Association established the Technology Evaluation Center (TEC) in 1985 to provide health care decision makers with timely, rigorous and credible assessments that synthesize the available evidence on the diagnosis, treatment, management, and prevention of disease. Current TEC clients include Kaiser Permanente and the Centers for Medicare and Medicaid Services.^{xvi}
- The Veterans Health Administration established the Quality Enhancement Research Initiative in 1998 to support the application of new research findings into routine clinical practice to improve the quality of health care for Veterans.^{xvii}
- The Agency for Healthcare Research and Quality (AHRQ), the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care in the United States, established the Effective Health Care Program in 2003 (under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) to support the production of health care effectiveness research for clinicians, consumers, and policymakers.^{xviii}

- The Oregon Center for Evidence-based Policy was created at the Oregon Health & Science University in 2003. Current projects of the Center include 1) the Drug Effectiveness Review Project (DERP), which supports the application of the best available evidence on effectiveness and safety comparisons between drugs in the same class to public policy and decision making; and, 2) the Medicaid Evidence-based Decisions Project (MED), which makes high quality evidence available to participating State Medicaid Programs to support benefit design and coverage decisions.^{xix}
- Washington state enacted a set of statutory provisions between 2003 and 2006 authorizing the state's public payers (Medicaid, Workers' Compensation, state government employee benefit plans, and the corrections department) to use evidence-based methods to improve the quality of care, reduce wasteful use of health care resources, and determine what benefits should be covered.^{xx}
- In 2006 the Institute of Medicine convened the "Roundtable on Evidence-Based Medicine", which is working through a series of workshops and publications to explore opportunities for achieving the Roundtable's goal that "by 2020, 90% of clinical decisions will be supported by accurate, timely, and up-to-date clinical information and will reflect the best available evidence."^{xxi}
- The Patient Protection & Affordable Care Act (P.L. 111-148) enacted in 2010 established a private, non-profit Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by carrying out research projects that provide high-grade, relevant evidence on how diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed. Members of the Board of Governors of the new Institute were recently appointed by the U.S. Government Accountability Office (GAO).^{xxii}

A critical aspect of EBM is the importance of understanding the quality of evidence and the appropriate application of evidence to an individual medical decision or population policy decision. Many unfortunate decisions have been made based on inadequate information or information derived from poor quality research or by those who misinterpreted the findings. The media is filled with stories of drugs being pulled off the market due to newly identified dangerous side-effects (e.g., Vioxx, Avandia, and Meridia), and commonly used medical therapies found to be potentially harmful (e.g., hormone replacement therapy) or no more effective compared to less invasive, less costly treatments (e.g., arterial stents). This has led to significant confusion on the part of the public and skepticism regarding whether to ever believe any medical research at all.

Skepticism on the part of the public is not misplaced – an estimated 90% of published medical information is flawed.^{xxiii} It is therefore essential that health care professionals understand how to translate evidence into practice. It is relatively easy to learn basic critical appraisal skills, and training in how to critically evaluate the medical literature and apply it is increasingly available. Methods for grading the quality of evidence and the strength of recommendations have been developed and are in wide use. A growing number of organizations evaluate clinical studies and make medical information based on high grade evidence available publicly. Other challenges to applying EBM in clinical practice, such as the overwhelming volume of research and information available to guide clinical decision making, should in time be more easily managed with the assistance and growing use of health information technologies by health practitioners and patients.

It should be noted that there has been some controversy around the term “evidence-based medicine.” Some borne out of concern that the intent is to turn clinicians into automatons through imposed decisions based on required instructions (“cookbook medicine”). Others who have heard the term in recent use by public entities fear it is a government initiative, intended to take individual health care decisions out of the hands of providers and their patients. It is neither, and acknowledging these potential concerns and ensuring the appropriate use of EBM can guard against these concerns becoming realized.

“Evidence based medicine is not “cookbook” medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients’ choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient’s clinical state, predicament, and preferences, and thus whether it should be applied.”

David Sackett, et al, 1996^{xxiv}

Resources available for health care are not infinite, and policy decisions regarding their use are made by health care payers in the public and private sector every day. Evidence-based medicine is a model of individual clinical practice and population policy decision-making that can serve to ensure limited resources are targeted to the most effective and efficient services. Application of evidence-based medicine to the public policy arena should not increase government control over health care decisions, but should ensure that government officials are being more responsible stewards of the public funds with which they are entrusted. The goal should always be to increase the quality of care and improve health care outcomes by ensuring information on which decisions are being made is valid and accurate.

The ideal health care system for Alaska should be designed to apply high-grade evidence in support of a collaborative health care choice for each patient and provider. The system should also be designed to support application of high-grade evidence by public officials who have the qualifications and training to critically appraise medical literature, and through a public process that is transparent and includes stakeholders in public policy decision-making regarding allocation of limited public medical care dollars.

In Alaska state government is a significant payer for health care services. State programs that purchase health care such as the Medicaid program, state employee and retiree health plans, corrections and Workers’ Compensation could provide leadership in incentivizing improved quality and efficiency of care through the use of evidence-based medicine. Public policies based on the application of evidence-based medicine should enhance the consumers’ role in health by fostering informed discussions between patients and providers with the goal of improving the health outcomes of medical decisions.

Recommendation A.3.a: The Commission recommends that the Governor and Alaska Legislature encourage and support State health care programs to engage in the application of high grade evidence-based medicine in making determinations about benefit design (covered services, prior authorization requirements, patient cost-sharing differentials) and provider payment methods.

Recommendation A.3.b: The Commission recommends that the Governor require State health care programs to coordinate development and application of evidence-based medicine policies to create a consistent approach to supporting improved quality and efficiency in Alaska’s health care system.

Recommendation A.3.c: The Commission recommends that the Governor require State health care programs to involve health care providers and consumers in decision making related to the application of evidence-based medicine to public policy. The purpose of such involvement is to support a transparent process leading to policies that avoid restricting access to appropriate treatment and that foster informed discussions between patients and clinicians in which individualized, evidence-based choices improve the quality of health care.

Recommendation A.3.d: The Commission recommends that the Governor direct State health care programs to seek to incorporate data on patient compliance in developing new provider payment methods and benefit design.

Recommendation A.3.e: The Commission recommends that the Alaska Department of Health & Social Services implement a web-based data system for public health information.

C. Strategies under Consideration for Study in 2011

Note: The numbering system for Strategies continues from 2009 and 2010.

A.1. Consumers' Role/Prevention: Healthy Lifestyles - On-line Community-Based Health Data System

During 2009 the Commission learned that chronic disease is the leading cause of death and disability in the U.S. and Alaska, that the majority of health care spending is for chronic disease, and that individual behaviors such as tobacco use, poor diet and inactivity are now the leading determinants of the health status of the population and contributors to premature death. The Commission recommended that the State investigate strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

Communities play an important role in creating local environments that support healthy lifestyles. Design of roads, walkways and public transportation systems; school policies regarding nutrition, physical education, and extracurricular activity; development of non-profit organization programs; local ordinances such as those pertaining to clean indoor air; and, organization of local medical services and systems are all examples of where communities can act to influence the health of their residents.

A critical resource for community health improvement planning is timely and relevant data on local health factors to guide identification and prioritization of program strategies, support alignment with health goals, and enable measurement of progress and evaluation of outcomes. During their November 2010 meeting the Commission heard from a representative of an Alaskan community health foundation about the need for and opportunity to develop a public access, web-based data and information system to support local health status reporting and improvement planning. The Commission identified this strategy as a priority for study during 2011.

A.2. Consumers' Role/Value: Primary Care Innovation - Next Steps

Primary care is the foundation of the health care delivery system – providing the main point of entry for secondary and tertiary care, and meeting the majority of patient needs for health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health conditions, and overall management of a patient's health care services. There is increasing evidence that access to high-quality primary care improves health outcomes and reduces costs. However, the rising demand for services from an aging population and increasing chronic disease, coupled with the decreasing supply of primary care physicians, is sweeping our primary care system toward a crisis.

In preliminary learning about innovative patient-centered primary care models during 2009 the Commission found that these models are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care. Key characteristics of patient-centered primary care include a stable trusting relationship between the patient and their health care practitioners; care that is provided by a multidisciplinary team; whole-person orientation (addressing all life stages, prevention and wellness, acute and chronic conditions, and both mind and body); care that is coordinated and/or integrated (including integration of primary medical care and behavioral health services); emphasis on quality and safety; and enhanced access (through open scheduling and modern communication options). The Commission recommended the State aggressively pursue development of these care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects.

During 2011 the Commission will engage in additional learning to identify more specific strategies for advancing the patient-centered primary care medical home model in Alaska, including strategies for integrating primary medical care with behavioral health services.

A.4. Consumers' Role/Value: Increase Price & Quality Transparency

Consumers need to know the price and quality of their health care options in order to make informed decisions and support their ability to participate more fully in their care, but the present system of health care pricing and reimbursement has been characterized as “forcing sick and anxious people to shop around blindfolded for cost-effective care.”^{xxv} Empowering consumers with information not only supports improved decision-making on their part, but drives the entire system to provide better care for less money. An infrastructure to support transparency of health care prices and quality for Alaskan consumers, compiling and analyzing data on pricing and quality measures for physician services and hospital care and producing public information through an accessible and understandable reporting mechanism, does not currently exist.

Creating a system to provide transparency is not as simple as it may sound however. Pricing of individual services might be misleading without a more comprehensive picture of the total cost of care for a given condition and the expected outcomes of various care options. And transparency to support a market-based approach is not the only solution to the health care cost and quality problem. Health care is different than other goods and services, and all the conditions required for a competitive market do not exist in the health care market. Consumers do not fully control all of their health care dollars, and they cannot participate fully in all aspects of clinical decision-making about their care. In addition, many health care decisions are made for consumers in urgent or emergent situations when the consumer is severely ill, injured or under too much emotional stress to participate in their care decisions.

The potential benefits of and barriers to developing a system providing price and quality information to support consumer choice need to be fully understood as part of a strategic approach to making the system more transparent with the goal of improving value (increasing quality/controlling costs). During 2011 the Commission will study national trends in price and quality transparency and identify opportunities for applying transparency strategies to improve value in Alaska's health care system.

A.5. Consumer's Role/Value: Bundled Payment Systems

The current fee-for-service payment system rewards health care providers for volume, not value. The financial incentives in this system lie entirely in the provision of more health care services and the sale of more health care commodities regardless of the quality of care provided, and may actually serve as a disincentive to creating health. Payment bundling is one value-driven payment method with the potential for rewarding quality over volume.

Payment bundling provides a global fee for a specified set of services. Development of this type of payment system could be phased in over time, starting with bundling of a limited set of hospital services related to certain acute care episodes (related to certain illness diagnoses for a specified period of time – for example, coronary artery bypass surgery and extending 30 days beyond discharge); and expanding over time to include physician inpatient care and post-acute care.

A particular challenge to implementing this strategy in Alaska is the lack of integrated care networks in our state. Hospitals would have to contract with physicians and other service providers required to deliver the suite of services potentially needed to treat the bundled diagnoses or procedures. Other challenges involve the lack of sophisticated information and accounting systems in many of Alaska's smaller hospitals, the need to identify standards to ensure changes in reimbursement do not negatively impact quality, mechanisms for avoiding “cherry-picking” of patients with the potential for fewer complications, and ways to reduce exposure to risk for providers. Research is required to guide implementation of new payment methods, and careful evaluation is required to assess cost-effectiveness, impact on quality of care and patient outcomes, and identification of unintended

consequences. During 2011 the Commission will analyze the opportunities for testing bundled payment systems in Alaska.

A.6. Consumer's Role/Value: Leverage State Purchasing Power

State government in Alaska represents a substantial payer for health care services. The state spent over \$1.5 billion in FY 2009 in Medicaid expenditures, state employee and retiree claims (not counting benefit credits paid to union health trusts), state employee Workers' Compensation medical claims, and purchase of health care services for incarcerated offenders in the state correctional system. In 2011 the Commission will study potential benefits and barriers to collaboration between these state programs to develop shared value-driven purchasing strategies --- leveraging their purchasing power to drive improved health care quality and cost in Alaska.

A.7. Consumer's Role/Access: Insurance Industry Regulation/Deregulation

One cornerstone of the new federal health care legislation (the Affordable Care Act) is reform of the private insurance market through a series of new federal regulatory requirements. The federal government envisions these reforms will be implemented through and by state insurance regulators. There are questions and concerns regarding the impact of these new requirements on the insurance industry, on future prices for insurance premiums, and on the States' role in insurance regulation.

Only 23% of Alaskans have health insurance purchased on the private market. An additional 32% have insurance through their employers' self-insured plan (exempt from state regulation under federal law (ERISA)). The remaining 45% of Alaskans have insurance through a public plan (Medicaid/Medicare), have health care provided by the military or the tribal health system, or are uninsured.^{xxvi} Consideration of insurance market reform strategies will require study of the potential impact on Alaska's health care system since less than a quarter of the population is covered by the state-regulated insurance market. During 2011 the Commission will study opportunities for improving access to and value of health care through insurance market regulation (and deregulation) in the context of the changes imposed by the Affordable Care Act.

B.3. Statewide Leadership: Measuring Health System Improvement

The Commission and State leaders in government, business and the health care industry need a mechanism for tracking how Alaska's health care system is performing over time, and whether Commission recommendations are having intended results in health system improvement. During 2011 the Commission will develop a set of indicators that are measurable and that best represent the status of our health care system relative to attainment of the four goals of increased access, controlled costs, improved quality, and prevention-focused. The Commission will also set benchmarks and targets for each measure, with the intention of reporting annually in future years on the progress of health system improvement. Following are examples of potential indicators.

Potential Health Care System Transformation Measures:

1. Increase Access
 - Percent of Alaskans insured
 - Percent of Alaskans who have a specific source of on-going care
 - *Measure of insurance affordability*
 - *Indicator of workforce supply*
2. Control Costs
 - Annual growth rate in total health system expenditures in Alaska
 - Annual growth rate in Alaska's Medicaid expenditures

- Impact on Alaska's state budget: new spending, net savings, new revenues
 - *Measure of provider revenues based on value*
3. Safe, High-Quality Care
 - Percent of population receiving key preventive services or screenings
 - Percent of Alaskans with chronic conditions controlled
 - Percent reduction in gap between benchmark and actual levels of quality
 - Percent reduction in gap between benchmark and actual levels of safety
 4. Focus on Prevention
 - Percent of Alaskan homes with safe water and wastewater systems
 - Percent of Alaskans reporting health risks
 - Percent of Alaskans who smoke cigarettes
 - Percent of Alaskans who are overweight or obese
 - Percent of Alaskans who are binge drinkers
 - Percent of Alaskans with moderate to severe depression
 - Death rate among Alaskans due to injury (intentional and unintentional)

C. Workforce Development - Next Steps

Alaskans' access to quality health care is dependent on the availability of a well trained health care workforce with sufficient numbers of workers in the right occupations and the right locations to meet the needs of the population. The Commission focused during 2009 on the physician workforce as just a first small step and only one component in what should be a comprehensive and sustained approach to development and implementation of a health care workforce strategy for Alaska. There are numerous organizations collaborating on various aspects of health care workforce planning and development, and further study and improvement of Alaska's health care workforce cannot occur in isolation but must consider and build on these other efforts, and a comprehensive approach to addressing Alaska's health care workforce needs must include strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of health care workforce planning, development and support infrastructure

During 2011 the Commission will coordinate with the Alaska Health Care Workforce Coalition to identify opportunities for sharing and leveraging resources to develop strategies for health workforce development in our state.

One specific workforce strategy that the Commission also intends to track during 2011 is improvement of the licensure process for health care professionals in Alaska.

Pending Strategies for Future Consideration

In addition to the policy options and other strategies for which recommendations were developed in 2009 and 2010 and those described above for consideration in 2011, the following options have been identified for study by the Commission at some point in the future. Most of these options were identified during 2009 and are briefly described in the Commission's 2009 report.

A. Consumer's Role in Health

I. Value (Cost & Quality)

- Move to value-driven purchasing
 - Pay-for-Performance
 - Medical error/infection reporting and non-payment
- Control fraud and abuse
- Reform the malpractice system
- Support process and quality improvement
- Increase consumer participation in payment for services
 - Health Savings Accounts
- Identify additional innovative patient-centered health care strategies to address
 - High-cost beginning and end of life care
 - Medicaid high-cost clients

II. Access

- Increase insurance coverage
 - New insurance programs
 - Health insurance exchange
 - Individual and/or business subsidies
 - Individual and/or business mandates
 - Medicaid Expansion
- Address availability of specific services
 - Behavioral health
 - Long term care
 - Trauma care
 - Clinical preventive services
 - Pediatric specialties

III. Prevention

- Safe water and sanitation systems
- Employee health risk management programs

B. Statewide Leadership

- Strengthen the Health Data Infrastructure

End Notes

- ⁱ Healthy Alaskans 2010 Volume I. Alaska Department of Health & Social Services.
- ⁱⁱ "Alaska's 10-Year Occupational Forecast," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.29, #1, January 2009.
- ⁱⁱⁱ 2007 Alaska Health Workforce Vacancy Study. Alaska Center for Rural Health, UAA. July 2007.
- ^{iv} See State of Alaska Medicaid Budget Impact Analysis included in the "Summary of Medicaid Requirements Included in PPACA" presented by DHSS to the Senate HSS Committee August 3, 2010 and included in Appendix B.
- ^v "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL", Prepared by the Urban Institute for the Kaiser Commission on Medicaid & the Uninsured, May 2010
- ^{vi} Alaska Health Care Commission, "Transforming Health Care in Alaska: 2009 Report/2010-2014 Strategic Plan," January 2010.
- ^{vii} Foster, M, Goldsmith, S. "Alaska's \$5 Billion Health Care Bill – Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.
- ^{viii} Institute of Medicine, "Crossing the Quality Chasm," National Academy Press, 2001.
- ^{ix} www.dartmouthatlas.org
- ^x Institute of Medicine, "Crossing the Quality Chasm," National Academy Press, 2001.
- ^{xi} Fisher, ES, et al, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Annals of Internal Medicine, 138, 2003.
- ^{xii} Wennberg JE, Fisher ES, Skinner JS, "Geography and the Debate Over Medicare Reform," Health Affairs, February 2002.
- ^{xiii} Claridge, JA, Fabian, TC, "History and Development of Evidence-based Medicine," World Journal of Surgery, 29, 547-553, 2005.
- ^{xiv} Sackett DL et al, "Evidence based medicine: what it is and what it isn't," British Medical Journal, 312:71-72, 1996.
- ^{xv} Eddy, DM, "Evidence-Based Medicine: A Unified Approach," Health Affairs, Vol. 24, No.1, Jan/Feb 2005.
- ^{xvi} <http://www.bcbs.com/blueresources/tec/>
- ^{xvii} <http://www.queri.research.va.gov/>
- ^{xviii} <http://effectivehealthcare.ahrq.gov/index.cfm>
- ^{xix} <http://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/>
- ^{xx} Franklin, GM, Budenholzer, BR, "Implementing Evidence-Based Health Policy in Washington State," N Engl J Med 361;18, October 29, 2009.
- ^{xxi} Institute of Medicine. 2009. *Leadership Commitments to Improve Value in Healthcare: Toward Common Ground: Workshop Summary*. Washington, DC: The National Academy Press.
- ^{xxii} <http://www.gao.gov/press/pcori2010sep23.html>
- ^{xxiii} Ioannidis JPA. Why Most Published Research Findings are False. PLoS Med 2005; 2(8):696-701. PMID 17593900.
- ^{xxiv} Sackett DL et al, "Evidence based medicine: what it is and what it isn't," British Medical Journal, 312:71-72, 1996.
- ^{xxv} Reinhardt, UE, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," Health Affairs, Vol.25, No.1, Jan/Feb 2006.
- ^{xxvi} Information provided by the Alaska Division of Insurance, November 2009.